



Manus Dental Patient Financial Policy

Welcome to our office! We are honored that you have chosen us as your dental care provider and look forward to working with you. Our dental practice team is committed to providing an excellent dental care experience to you and your family and has implemented the financial policies outlined below to assist in that regard. These financial policies are followed by our practice so that we can stay focused on what we do best – providing you with personalized, comprehensive dental care services. Thank you in advance for your cooperation.

- 1. Payment for all treatment is due at the time services are rendered unless other payment arrangements have been made with our team in advance.*
- 2. Payment for services may be made by cash, check, Visa and MasterCard.*
- 3. The practice has arranged special dental care financing programs with a number of third party financial institutions. These special financing programs were arranged to reduce the financial barriers for our patients in receiving optimal dental care treatment. Please ask your doctor or practice administrator for further information regarding these special financing programs.*
- 4. Fees quoted for treatment will remain in effect for 90 days and thereafter are subject to change without notice. In the event clinical conditions warrant a modification in treatment, you will be notified of modifications in treatment and the associated fees prior to proceeding with the modified treatment.*
- 5. If you fail to show for a scheduled appointment or cancel an appointment with less than 48 hours advanced notice and the practice is not able to appoint another patient during the time reserved for you, the practice may charge you a fee for such broken or late-changed appointment. The fee for broken appointments is \$50 per appointment.*
- 6. You may be referred to an in-office specialist to meet your specialty treatment needs. The referring dentist may benefit financially from this referral although this will not have any affect on the diagnosis of treatment.*
- 7. If a check provided by you to the practice in payment for services delivered is returned due to insufficient funds or otherwise there will be a \$29.00 returned check fee added to the amount due.*
- 8. If services are not paid for at the time services are delivered you will be provided a statement for the amount due and will be expected to pay that amount in full promptly following receipt of the statement. If the amount due is not paid in full within 30 days of the day services are delivered you will be charged interest on the outstanding amount retroactive to the day of service at a rate of 1.5% per month, or 18% annually, and will be subject to a late payment fee of \$29.00 (\$39.00 for amounts over \$1,000.00) for every 30 days or portion thereof the amount due remains unpaid. If the amount due is not paid in full within 30 days of the day services are delivered the practice may, among other remedies, refer the collection of the unpaid amounts to a collection agency or collection attorney and, in such a case, you will be responsible for any and all fees and expenses of the collection agency or collection attorney relating to the collection of the unpaid amounts.*

If you have dental insurance the practice will work with you to maximize your allowable insurance benefits and will assist you in making necessary filings with your insurance company. It is understood that the practice will diagnose treatment based on your dental health and not your insurance coverage. It is further understood that, since your insurance is a contract between you and your insurance company / employer, the practice cannot assume responsibility for coverage or other determinations made by your insurance company and that you will be responsible for timely payment for all treatment received from the practice regardless of your insurance status.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

Patient Name (Please Print): _____

Patient Signature: _____

Date:
