ROSE
DENTAL CARE

TREATMENT AND FINANCIAL POLICY

PATIENT/PARENT NAME: _____ **DOB**: _____
DEPENDENTS: _____ **DOB**: _____
_____ **DOB**: _____
_____ **DOB**: _____

The following is a statement of our financial policy, which we ask that you read, agree to, and sign prior to any treatment.

PLEASE NOTE: Additional fees will be applied for returned checks. All account balances over 90 days will be subjected to a $35.00 late fee.

IF YOU HAVE INSURANCE:

As a courtesy to you, we will help you process all your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequencies, age restrictions, deductibles, and maximums which are your responsibility. We are the dental office, not the insurance company we must abide by all of the eligibility and benefit limitations they apply. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do our best to ensure your estimate is as accurate as possible.

We require you pay the deductible, co-payment, and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover, American Express, and or Care Credit at the time we provide service to you.

Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we ask that you contact your insurance company to make sure payment is as expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at the time of treatment.

We will cooperate fully with the regulations and request of your insurance company that may assist in the claim being paid. We will do our very best to make sure your treatment is covered. Our office will not however, enter any dispute with your insurance company over any claim.

MINORS ACCOMPANIED BY PARENT/LEGAL GUARDIAN: The patient or legal guardian accompanying a minor, who has consent to treatment, is responsible for full payment at the time of service.

UNACCOMPANIED MINORS: The parent or legal guardian is responsible for full payment at the time of payment at the time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency treatment may be denied.

COMMUNICATIONS WITH YOU:

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for lawful purposes. You agree to any fees or charges that you may incur for an incoming call from us, and our outgoing calls to us, to or from any such number, without reimbursement from us. We or our agents may call by telephone regarding your account. You agree that we may place such calls using an automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device. You agree that we may also listen to and record phone conversations you have with us for training or quality purposes.

CONSENT:

I have read, understand, and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that I am responsible for all payments not covered by my insurance (all payments if I do not have insurance), for myself or my dependents, due at the time of treatment.

CANCELLATION AND RESERVE FEE POLICY:

Here at Rose Dental Care, providing our patients with our best and most concentrated care is top priority. In order for us to do so, we may require a reserve fee for appointments as we see fit. We also have a cancellation policy in place to preserve our doctor's time and insure she can care for our patients to the best of her ability.

RESERVE:

A reserve fee may be required for any appointment that the doctor or staff deems necessary. This may be based off of the treatment being done, the heaviness of the schedule, or the patient's attendance history. The reserve fee can range from $25.00 to 50% of the cost of the treatment. Our doctor's time is valuable and our reserve fee for the patient's appointment will be used towards the cost of treatment unless the appointment is broken. (see cancellation policy).

CANCELLATION:

We ask that if you need to cancel or reschedule your appointment, you give us notice at least three business days in advance. This way we can give the appointment to other patients in need of treatment. If an appointment is cancelled or rescheduled after three business days, or you no call/no show, our cancellation policy will fall into place. We will do one courtesy reschedule per quarter for patients in good standing with our cancellation policy will fall into place. For all others, we will require a minimum $25.00 reserve fee for ALL appointments scheduled after the breaking the initial appointment if an appointment with a reserve fee in place is cancelled outside of our cancellation policy, the reserve fee will be held at the doctor's discretion.

SIGNATURE: _____ **DATE**: _____