ECKMAN FAMILY DENTISTRY

Joseph F. Eckman, D.D.S Joseph F. Eckman, Jr., D.M.D

FINANCIAL POLICY and CONSENT

Dear Patient:

Thank you for selecting us as your dental health care provider. The following information describes our Financial Policy and Consent. Our primary goal is that you receive the optimal treatments needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to ask one of our office managers.

Payment for services is due at the time services are rendered. We accept cash, personal checks, and for your convenience Mastercard, Discover, American Express and Visa. We will help you process your insurance claim for your reimbursement as long as we have complete insurance information.

1. Your insurance policy is a contract between you, your employer, and the insurance company.
We are NOT a party to that contract. Our financial relationship is with you, not your insurance company.

2. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

3. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.

4. If the insurance company does not pay your balance in full within 30 days, we will ask that you contact the carrier to help speed things up.

5. If the insurance company does not pay in full within 45 days, we will require you to pay the balance due with cash, personal check, Mastercard, Discover, American Express or Visa.

6. Balances older than 90 days may be subject to additional collection fees and interest charges. Returned checks will have an additional fee of $35.00 added to the amount of the returned check.

Please note that, unless canceled at least 24 hours in advance, you may be charged for missed appointments at the rate of a normal office visit. Please call the office as soon as possible if you have to reschedule. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us so that we can assist you in the management of your account. Again, thank you for choosing Eckman Family Dentistry as your health care provider. We appreciate your confidence in us and the opportunity to serve you.

Consent:

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor or hygienist to make a thorough diagnosis of _____’s_ (Name of Patient) dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

Patient’s/Guardian Signature: _____ Date:_____
Relationship to Patient_____ Date of Birth_____
Social Security #_____Address_____