ESSENTIAL DENTAL CARE

FINANCIAL POLICY

Thank you for choosing us as your oral health care provider. We are committed to providing you with outstanding patient care and service.

Please understand that payment of your account is considered part of your treatment. Your prompt payment helps cover the cost of your care and allows us to continue to provide these services to you and others. The following is our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Patient and Insurance Information form prior to seeing the doctor.

PAYMENT: Payment is expected in full for each appointment as services are rendered. Payment options include:

- Cash
- Checks
- Credit Card – Visa, MasterCard, Discover, American Express
- Special Financing – Care Credit, Chase Health, In-House Extended Payment Plan

REGARDING INSURANCE: As a courtesy to you, our patient, we will submit your claim to your insurance company for payment.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits, we require that you be pre-approved on your extended payment plan or provide a credit card with authorization to bill that account for the balance. *If your insurance company has not paid your account in full within 45 days, the balance will become the patient's responsibility and will be billed directly.* Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary, or necessary under your dental plan insurance policy guidelines. After your insurance provider determines what they will pay based on your individual benefit plan, **the balance is your responsibility** whether your insurance company pays or not. We have no control over the terms of your contract, the method of reimbursement, or the determination of your benefits. Any discrepancy over benefits or payment of your claim is between you and your insurance carrier. We encourage you to call them if a discrepancy should occur.

In the event that the assigned benefits from your insurance are greater than expected, your account will be credited for the overpayment and you will be refunded.

In regards to Insurance Plans where we are a participating provider, all co-pays and deductibles are due prior to treatment.

PLEASE TURN OVER

Dr. Schubert Sapian
2950 W. Camp Wisdom Rd., Ste. 300
Grand Prairie, TX 75052
972-641-2900/essentialdental777@gmail.com

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RESPONSIBLE PARTY: The patient, parent or guardian, and/or guarantor of the insurance policy is deemed financially responsible for the patient's account.

PAST DUE ACCOUNTS: Any claim not paid after 60 days will be subject to a FINANCE CHARGE of 18% Annual Interest compounded monthly (1.5% per month) or a minimum of $2.00 monthly and may be referred to an outside collection company for payment and/or reporting through a credit agency.

MISSED APPOINTMENT: Please understand the doctor has allotted time and resources specifically for your treatment. If there is a change in your schedule that requires a cancellation, please allow us 48 hours advance notice so that we can reappoint these resources for another patient. If less than 48 hour charge will be applied to your account.

RETURNED CHECKS: There is a fee ($35.00) for any checks returned by the bank.

I have read the above conditions of treatment and payment and agree to their content.

By signing and dating this form, I give consent for treatment to Dr. Sapian and his associates.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment

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