

Elements Family Dentistry
Yvette L. Killingsworth, DDS, PC
OFFICE FINANCIAL POLICY

Regarding Payment:

- We accept cash, checks, Visa, MasterCard, Discover Card, American Express, Health Savings Accounts and Care Credit for your convenience.
- A finance charge may be imposed on those charges not paid in full within 30 days. The finance charge is 1.50%.
- There is a fee of \$25 for returned checks.
- ANY payment arrangements must be *mutually* agreed upon **PRIOR TO TREATMENT BEING STARTED.**

Regarding Insurance:

Patients with insurance are required to pay their deductible and coinsurance at the time of treatment. We are happy to submit the claims necessary to see that you receive the full benefits of coverage. However, we cannot guarantee any estimated coverage. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. Any changes to your benefits year to year are your financial responsibility. It is YOUR responsibility to see that the claims are paid to our office promptly. **YOU are responsible for the payment of your account whether or not your insurance company makes a payment.**

Regarding Past Due Accounts:

I understand that failure to pay the full balance of my account, Dr. Killingsworth will take necessary steps to collect this debt. A third party Collection Agency will become involved. I understand that I will be responsible for any fees and charges associated with collection. All lawyer fees that are incurred, plus any court costs will be my responsibility. I understand if this account is submitted to a collection agency or attorney, or we have to litigate in court my record becomes public and information will be shared with appropriate venues involved.

Regarding Divorce:

In regards to minor children, we bill the remaining balances to the *insured party*. In the case where there is no insurance, we bill the authorizing parent who brings the child to the office. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent, NOT the responsibility of the office.

Regarding Appointments:

Please be considerate to the appointment scheduled exclusively for you. Notice of **TWO BUSINESS DAYS** is required for rescheduling appointments. Please understand that Dr. Killingsworth reserves the right to charge a \$75 broken appointment fee. Multiple broken appointments may warrant being released as a patient from the practice.

We reserve the right to make changes to this financial policy without notification. It is the responsibility of the patient to ask questions pertaining to their insurance and financial matters prior to treatment.

I, _____, have read, understand and agree to the above financial policy.

Patient or Responsible Party

Date