Financial Polices

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

Payment Policies: Full payment is collected at the time services are rendered. If a treatment plan requires multiple stages, payment will be required at the time services for that stage are rendered. We accept Cash, Checks, Visa, MasterCard, Discover, American Express, and Care Credit. **A NSF fee will be charged to the patient in the event that their check is returned to us for non-payment.**

Dental Insurance: If you have provided us with your dental benefit information, we will file your claim as a complimentary service for you. If you are in-network, your co-pay and/or deductible are due on the day of service. We are happy to provide you with an **estimate** of what we believe your dental benefits will cover based on the information provided to us from your benefit provider. Please know that we **cannot** guarantee what will be covered by your dental benefits. Preauthorization by your insurance company is not a guarantee of the quoted benefit. We are happy to help you review your dental benefits and answer any questions you have, however, you are responsible for understanding your benefits. You have ultimate financial responsibility for your account regardless of whether your dental benefit provider covers your treatment. **Insurance will not guarantee any benefit until we actually file the claim**. I also understand that I am responsible for any copayments, deductibles or billable charges due to plan limitations/exclusions and/or that are **not covered and/or denied** by my insurance company. The patient is responsible for any additional monies owed after insurance pays.

Medical Benefits: We are not contracted with any medical plans. We will take a copy of your medical insurance cards to put on file but we will not bill any medical companies. We are more than happy to give you anything you need for you the patient to bill your medical on your own for insurance to reimburse you directly.

Patients with Medicare: We are not contracted with Medicare and Dental procedures are not billable expenses to Medicare. Because we are not contracted with Medicare we cannot file any claims with them and neither can the patient. However, if you will be having a biopsy, please provide us with your Medicare information and we will send you Medicare information with the biopsy for the University of Florida to bill them for the testing.

Cancellation and Failed Appointments: We work hard to stay on schedule for you and expect the same level of consideration from our patients. Because instruments, chairs and personnel are reserved exclusively for your appointment we ask if you anticipate that you will not be able to honor your reserved appointment time, please contact our office with 24 hours. Patients who are repeatedly late or are absent for scheduled appointments may be dismissed from our practice.

Minors: If a patient is under the age of 18, a parent or legal guardian must accompany the patient to each appointment to review medical history, authorize treatment unless prior arrangements have been made with the office manager prior to the patient appointment. In the case of divorced or separated patents, it is YOUR responsibility to have financial arrangements made according to the divorce decree before treatment begins.

Patient's under 21 years old: If the patient is under 21 years old we must know who is responsible to the patient's account. If the patient's account ever ended up with a refund that we needed to send back to the patient please clearly list the name and address this refund would go to: _____

By signing below you that you have read and understand and agree to the above policies. I also certify that the information I have reported with regard to my insurance coverage is correct and I authorize the release of any information relating to any claim for benefits, in order to process any claim for benefits. I hereby authorize payment of dental benefits to be made directly to Dr. Ralph Eichstaedt for his services. Furthermore, I permit a copy of this authorization to be used in place of the original.

Print Patient's Name: _____ Date: _____

X _____

Signature (patient's that are 18 years and older must sign this form. The signature of a parent, guardian or spouse is not acceptable)