BRANT SMILES FINANCIAL POLICY

Thank you for choosing *Brant Smiles Family Dentistry* as your dental care provider!
Dental treatment is an excellent investment in your overall health and well-being. We are committed to providing you with the best possible care to achieve your dental goals.
The following is a statement of our financial policy.

We value your business and ask that you respect our business scheduling policies. We require a minimum of 48 hours notice to change your reserved appointment time. For any appointments cancelled or missed entirely without this notice will be charged a cancellation fee of $50.00.

_____ (initials)

OPTIONS FOR PAYMENT OF TREATMENT:

1. *NON-INSURANCE PATIENTS*

Payment is expected at the time of service for treatment performed that day unless prior arrangements have been made. For your convenience, we accept Cash, Visa, Mastercard and Debit.

2. *PATIENTS WITH INSURANCE*

PLEASE NOTE: OUR OFFICE FEES ARE AS PER THE CURRENT ONTARIO DENTAL ASSOCIATION FEE GUIDE

As a courtesy to our patients who have dental insurance coverage, we will be happy to file your claim electronically. Your deductible and co-payment are due on the date of service

_____ (initials)

Claims to secondary insurance carriers are also filed for patients as an office courtesy. The remaining balance after both primary and secondary payments have been applied to your account, will be the patients' responsibility

_____ (initials)

Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. As dental care providers our financial relationship is with you, the patient, not your insurance company. The financial responsibility for your treatment is yours whether the insurance company pays or not

_____ (initials)

Any deductible, estimated percentages (co-pay) as well as fee guide differences in which your insurance does not cover, they are to be paid on the date of service

_____ (initials)

It is the patients' responsibility to know the details of your dental insurance benefits, including percentages payable, waiting periods, deductibles, yearly maximums, services not covered under the plan, and any other related information

_____ (initials)

For patients with insurance of a "Non-assignment" plan, means that the insurance company will only pay the plan member directly. Therefore, payment is expected in full on the date of the treatment

_____ (initials)

Insurance payments are typically received within 14 days provided you have provided us with the correct details of your plan. If your insurance company has not paid their liability in full within 30 days, the balance then becomes the patients' responsibility

_____ (initials)

Should you have any questions regarding this policy, please speak to one of our office Administrators. We are most willing to help you in any way possible.

I, _____ authorize *Brant Smiles Family Dentistry* to charge my credit card as listed below for amounts <u>not</u> covered by my dental benefits company which would include co-payments and payments <u>not</u> received **within 30 days** of the treatment being completed.

CREDIT CARD # _____

EXPIRY DATE: _____ CVV#: _____ CARD TYPE: _____

mm/yyyy (3 digits on reverse) (Visa OR Mastercard)

I HAVE READ THIS FINANCIAL POLICY AND UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS AS OUTLINED

_____ _____

Patient/Guardian Signature Date

_____

Office Administrator Signature