Susan Hollinsworth, D.D.S., P.S.

Creating a Healthier World, One Smile at a Time

FINANCIAL POLICY

Thank you for entrusting your dental care to us. We appreciate the opportunity to serve you and are committed to your health and well being. We want you to know what the financial expectations are before we begin any treatment as this helps both of us to plan treatment accordingly.

PLEASE READ AND SIGN BELOW

1. You are responsible for payment of the services you receive in our office regardless of insurance coverage. Please understand that your dental insurance is a contract between ***you and your insurance company, not between the dentist and the insurance company.***
You are ultimately responsible for any unpaid balance.

2. As a courtesy, we will prepare and submit your dental claims. It is *your responsibility* to know your plan benefits, deductibles, maximums, and covered services. We are only capable of approximating your portion due to the large number of insurance companies and to periodic changes in their contracts without notification to the dental offices. We will do our best to assist you in obtaining information, but ***we cannot be responsible for knowing your specific plan.***

3. Your patient portion not covered by insurance is due ***at the time of service.*** We accept the following payment options: cash, check, debit card, Visa, MasterCard. We will provide you with a receipt for payments upon request.

4. We offer a 5% bookkeeping courtesy if you pay in full with cash or check at the time of or prior to your appointment.

5. We are pleased to offer *no interest and extended* payment plans through Care Credit. Information is available at the front desk. Any other arrangements need to be approved through the financial coordinator.

6. We require 48 hours notice for rescheduling or canceling an appointment or a missed appointment fee will be charged.

I understand and agree to the financial policies above and authorize my insurance benefits be paid directly to the office of Dr. Susan Hollinsworth.

Patient/parent/guardian_____Date_____

Print name_____