APEX ENDODONTICS OFFICE FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. Our primary responsibility is providing the highest quality dental care. Part of our commitment is your understanding and responsibility for the payment of your account balance

INSURANCE AND PAYMENT POLICIES

- **FEES FOR SERVICE AT OUR OFFICE WILL BE DUE IN FULL AT THE TIME OF YOUR VISIT.**
- For patients with Dental Insurance: We currently participate with multiple insurance companies, please inquire if we are in network with your particular plan. All other dental insurance plans are accepted on an out-of-network basis
  Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. ID required at time of check in.
  We will file your claim for you; however, we ask that your deductibles and your estimated portions be paid as services are rendered. Any insurance claim not settled within 60 days will be due in full, any and all account balances are ultimately your responsibility. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. You are responsible for the entire balance.
  All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment. If you have two dental carriers**, we will file the primary claim but it will be your responsibility to file and follow up on any secondary claims.**
- Please note, for your convenience, we do accept AMEX, VISA, MasterCard, Discover and Care Credit as well as checks and cash. Any returned check will carry a $50 fee.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask as a courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we require a 24-hour notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $75, or no reappointment.**
- Our office will provide confirmation calls to you. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm your appointment. Failure to do so may result in your appointment needing to be rescheduled.
- The policy in our office is that the parent/guardian present is responsible for full payment at the time of service for a minor patient.
- Accounts unpaid after 60 days from day of service are subject to a $35 delinquent fee. If we have to submit your unpaid account to a collection process you will be responsible for all charges our practice incurs; including collection fees, court costs and reasonable attorney fees.
- If complications or problems arise from your visit, we ask that you direct your concerns directly to our office before addressing them with an outside source.

Our entire staff is dedicated to you. Please let us know if you have questions or concerns.

CONSENT: I have read this Financial Policy. I understand and agree to the terms of the Financial Policy of Apex Endodontics The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures deemed necessary. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date _____ Signature _____(Patient, Parent or Guardian)