TEDFORD DENTAL

your family's dentist

Financial Policy

We are committed to providing you with the highest quality dental care at the best possible price. This financial policy is, therefore, intended to facilitate our ability to provide excellent service to you in a way that also keeps our administrative costs down. This, in turn, allows us to keep our fees as low as possible.

Dental Insurance:

- Any and all charges incurred are *your* responsibility, regardless of your insurance coverage. We must emphasize that, as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company.
- As a courtesy to you, however, we will (in most cases) help process your insurance claims. In order for our office to file your claims, you must bring proof of current insurance to each appointment. Insurance payments ordinarily are received within 30 - 60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You then will be responsible for seeking reimbursement from your insurance company directly.

Payments and Financing Option:

- Payments (including insurance deductibles and/or co-payments) are due and expected **at the time service** is provided, and our office accepts personal checks, MasterCard, Visa, Discover and American Express. Although in-house financing is not available, financing is available through CareCredit.com as well as LendingClub.com. Please request more information.

Additional Fees:

- Returned checks will incur a $50 NSF fee.
- Balances older than 90 days will incur billing charges and finance charges at the rate of 1.5% per month (18% annually).
- Balances older than 90 days will be turned over for collection and subject to collection fees.
- Missed or Broken Appointments (cancelled without 24-hour advance notice) are subject to a missed appointment fee of **$65 per hour scheduled**.

If you have any questions regarding our financial policy,or would like a copy of this policy please request.

We are committed to providing you with the most positive experience in dental care.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I ALSO AUTHORIZE MY INSURANCE COMPANY (if applicable) TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

Signed_____ Date_____

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