Payment/Copays/Deductibles

Payment for co-pays and/or deductibles is due at the time services are provided. We have several options for payments of services, which may be paid in the following manner:

1. Payment by cash, Visa, MasterCard or Discover Card.

1. Payment by CareCredit Care Credit is broiling for qualified applicants who prefer additional time

to pay their balrotce. It is a revolving line of credit through an independent finrotcial institution. It is

designed to meet the needs of our patients and IS Ideal for extended treatment plans, elective ------­

procedures, emergency care and treatment not covered by insurance. Care Credit has fmro1cing options available that include six (6) month interest free payment plans, as well as an extended payment plan.

1/We understand the above paragraph regarding payment for services, and have had the opportnnity to

have any questions answered to the best of Dr Camman's and her staff's ability.

,;Signature of Responsible Party Date

Account Balances/Charges

A returned clteck fee of $45.00 will be applied to your accow1t for any personal check retun1ed w1paid or witl1 non-sufficient funds. Balro1ces older than ninety (90) days will be subject to an additional billing charge of *$5.00.* Any balance older d1ai1 90 days will be subject to interest charges of 1.5% per montl1 w1til the accow1t is paid in full. Ifa payment has not been received on the account during tl1e 90 days, dte accow1t risks being sent to a collection agency a11d additional collection fees will be applied to a11y unpaid

balrotce. Any atton1ey or collection fees incurred due to delinquency in payment will also be charged to dte patient We do w1derstand that temporary fmro1cial problems may affect timely payment of your accow1t

If dtis is a concern we do ask that you contact us promptly for assistance in the maiiagement of your

accow1t

1/We understand the above paragraph regarding payment for services, and have had the opportunity to

have any questions answered to the best of Dr Camman's and her staff's ability.

---------------:Signature of Responsible Party ----------'Date

Cancellations and Broken Appointments

In ail effort to keep dental costs down willie maintaining a high level of professional care, we respectfully request a 48 hour cancellation notice. Your scheduled time has been saved only for you a11d the doctor a11d/or hygienist Due to staff overhead d1at occurs in broken appointment slots, a cancellation fee is cltarged if a 48 hour notice is not given. Our message system will accept your cancellation calls for you and will record time/date of your call to avoid a $50.00 charge to your account We appreciate your efforts to keep sclteduled appointments a11d we will make every effort to continue to have convenient hours and prescheduled appointments availability for you.

1/We understand the above paragraph regarding payment for services, and have had the opportunity to

have any questions answered to the best of Dr Camman's and her staffs ability.

.Signature of Responsible Party D.ate

FINANCIAL POLICY

# DR CONSTANCE CAMMAN, D.D.S.

* + (Patient name)

## We welcome you and your fam1ly to the office of Dr Constance Camman. We look forward to providing you with the most exceptional dental care. To provide you with the most beneficial and comprehensive service and care, we do ask that you review and complete our office financial policy and consent forms. We strive to keep you informed and involved with your treatment as much as possible.

DENTAL INSURANCE

(initials).I/We DO NOT have dental insurance

## ------..l.·initials) 1/We DO have dental insurance (if so, please continue below).

If you have dental insurance, we will file tl e c aims for you, as a complimentary service. We do ask tltat tlte correct insurance information be provided at the time of your appointment·in order for us to timely file the claim and collect payments. *H* this information changes, it is the patient's responsibility to update our

office. We do accept paymentS from the dental insurance companies; however, we are not contracted with them. It is a.contract between you, your employer and the insurance company.

Our staff will provide you witl1 an ESTIMATE of your out of pocket expense for any treatment planned by the doctor. However, please w1derstand tltat these are STRICTLY FSTIMATES and nota guarantee that your insuran company will reimburse us/you according to thes estimates. It is possible that we could preautltorize any treatment to verify plan coverage and benefits. The tun1arow1d of tllis information from your insurance company is usually tllirty (30) days.

Please note that any difference in payment from your insurance company and your account balance is your responsibility. We emphasize tltat as dental care. providers, our relationship is with you; NOT your insurance company.· 'Willie the filing of insurance claims is a courtesy tlta we extend to all of our patients, all charges are your responsibility from the date the services are rendered. Ifdifficulcy arises witl1 payment from tlte ipsurance company, we. will ask thatyou.contact your carrier to rectify.tlte problem. All expected ttsurance balances remaining w1paid after sixtY·(60) days from the date of service becomes the immediate responsibilicyof the patient and/or accow1t hold r.

PAYMENT FOR SERVICES (YOUR COf Y/COINSURA.NCE) .IS DUE\_AND COLLECTED AT THE TIME THE SERVICES.ARE PROVIO;ED.

1/WE UNDERSTAND THE ABOVE PARAGRAPH REGARDING DENTAL INSURANCR AND HAVE HAD THE OPPORTUNITY TO HAVE ANY QUESTIONS ANSWERED TO THE BEST OF DR CAMMAN'S AND HER STAFF'S ABILITY.

------------- -\_.Signature of Responsible Party Date \_

Wibtess Date \_