THE TOOTH SHOP OF OCALA, LLC
1226 SE 24th ROAD ◆ OCALA, FL 34471 ◆ (352) 732-2458

FINANCIAL POLICY AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. In order to reduce confusion and misunderstanding between you and the practice, we have adopted the following financial policy which we require that you read, agree to, and sign prior to any treatment. If you have any further questions about the policy, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

In order to enhance communication and promote understanding regarding this office's financial and missed appointment policy, please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment.

INSURANCE: We are happy to bill your primary insurance carrier as a courtesy for our patients. Please understand that each patient is ultimately responsible for the cost of services rendered. Your insurance policy is a contract between you and your insurance company. We are NOT a party to that contract. Our financial relationship is with you, not your insurance company. You are responsible for knowledge of your insurance coverage and its limitations. This information should be readily available from your insurance provider. Many insurance companies pay based on a "Usual & Customary (UCR) fee." In some cases our fees may be *higher* than your insurance company's UCR fee. This is especially true if we are not "in network" with your insurance plan.

- All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts.
- If the insurance company does not pay your balance in full within 30 days, we will ask that you take responsibility for contacting your insurance carrier.
- If the insurance company does not pay in full within 45 days, we will require you to pay the balance due with cash, personal check, or major credit card.
- We will do our best to estimate insurance coverage and patient portions due. We can send pre-estimates for services over $500 at your request. If the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Payment is expected within 10 days after the statement date.

PATIENT PAYMENT: Payment in full is due at the time services are rendered. We accept cash, check, and all major credit cards. For treatment involving multiple appointments (crowns, bridges, implants, root canals, dentures, etc.) payment in full is expected when treatment has started. Financial arrangements must be made in advance allowing for 50% paid in full at start of procedure. The remaining 50% must be paid in full prior to completion of the procedure by cash, major credit card, money order, or cashier's check. A personal check must clear through the bank before payment is considered paid in full. We may offer a flexible payment plan using your Mastercard® or Visa® credit card (not a debit card), set up with automatic recurring payments. You may also apply for outside financing through CareCredit©, and if approved, CareCredit© may extend payments over a course of 12 months or more with deferred interest (which can be avoided with on time payments.) CareCredit© is subject to terms.

BALANCES: A service charge of 5% per month on any unpaid balance will be charged on all accounts exceeding 60 days from date of service, unless previously written financial arrangements are agreed upon and satisfied. Balances over 90 days will incur an interest charge of 18% APR. Additionally, a $5.00 rebilling fee per statement will be charged. Returned checks will have an additional fee of $40.00 added to the amount of the returned check.

Please sign page 1 of 2

Patient (print):_____ **Signature:**_____ **Date:**_____

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FINANCIAL POLICY AGREEMENT – (continued)

MISSED APPOINTMENTMENTS: We fully understand that life can be unpredictable and many times things come up unexpectedly. However, please understand that your appointment time is reserved especially just for you, and we truly do look forward to helping you with your dental needs. When life does take an unexpected turn and you cannot make it to your dental appointment, we respectfully request that you notify us at least 24 hours ahead. If you missed the first appointment without notifying us, we will kindly ask that you not do that again. The second time you miss your appointment, we reserve the right to charge to your account a missed appointment fee of $45 dollars. You will have to pay the fee prior to making another dental appointment with us. If you missed the third time without notifying us, you will be put on a walk-in status only or we may decide to terminate our relationship with you and ask that you seek dental services somewhere else. You will be allowed to get emergency dental services for the next 30 days while you look for a new dental home. We thank you ahead for your cooperation and hope that we will never have to implement this policy.

REFUNDS FOR UNFINISHED TREATMENT: Please understand that if a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office manager and/or the dentist.

CREDITS ON AN ACCOUNT: If an insurance company pays more than anticipated amount creating a credit for the patient, we are happy to either issue a refund to the patient or leave a credit on the account to be applied towards future treatment.

DEPOSIT POLICY
For long appointment times (over 2 hours), a down payment may be required to reserve the appointment. At least 48 hours' notice is required to cancel or reschedule. Failure to give proper notice may result in forfeiture of deposit and a cancellation fee.

I have read and understand the above financial agreement. Any questions and concerns were answered fully to my satisfaction. I understand that I am responsible for all fees and/or balances due and agree to pay them in a timely manner in order to avoid any additional charges. I, the undersigned (patient or legally responsible party) hereby authorize treatment to be rendered and assume all financial responsibilities. Furthermore, I authorize release of any information relating to my insurance claims and the assignment of any and all dental benefits paid directly to Niles A. Syska, DDS or The Tooth Shop of Ocala, LLC., I also authorize my credit information may be accessed when necessary. I understand that I am responsible for all costs of dental treatment and any additional costs incurred in collecting this account, including interests, court cost and attorney fees, will be added to my balance. By executing this agreement, you agree to pay for all services that are received. Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

By signing this form I am certifying that I have general authority to perform all acts on my own behalf, make my own financial decisions, and that I am responsible for my own finances. No other person or persons holds a Power of Attorney on my behalf.

Please sign page 2 of 2

Patient (print):_____ **Signature:**_____ **Date:**_____