RENEW DENTAL

## Financial Policy

Patient's Name: _____ Date of Birth: _____
(Printed) Last First

Payment for services, including deductibles and copayments, is due at time of service unless other arrangements have been made prior to treatment. Payments may be made using cash, check, or credit cards (Visa or MasterCard only). Any arrangements for third party financing must be made before starting treatment.

Renew Dental, PLLC accepts all dental PPO plans and is a provider of Delta Dental insurance plans. We are happy to submit the claims necessary to see that you receive your benefits. We cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed. The insurance contract is an agreement between you and/or your employer and their insurance company. You are ultimately responsible for all charges.

We can provide estimates for our cost of services after the comprehensive exam. Predetermination of benefits with insurance benefit plans may be advisable if there is a question concerning coverage. This can take 2-4 weeks dependent on your insurance carrier.

In order to maximize your benefits and because plans differ from carrier to carrier, and from policy to policy, our office may refer you to your carrier or your employer's benefits coordinator for assistance in understanding your plan. Please note that dental insurance is intended to cover some but not all dental care costs, and not all services are covered. You are responsible for payment of all services regardless of the payable benefit.

Nonpayment, payment reversal, or default of the terms agreed upon in a signed financial agreement will be assessed any bank fees, legal fees, and collection costs incurred including attorney fees. Any unpaid amounts remaining on your account shall after 30 days be sent to collections.

Checks that are returned to our office from your financial institution are subject to a $25 returned check fee. This fee covers administrative fees and the processing fees that are charged to our office. We would be happy to discuss our charges and how they relate to your particular situation.

**Please indicate your understanding and acceptance of these financial policies by signing below.**

Signed: _____ Date: _____
*Patient*

**Parent/Legal Guardian (Guarantor of Payment)**

Relationship to Patient: _____

Name (printed): _____

Signed: _____ Date: _____

Staff: _____