inspired DENTAL

Financial Policy

At Inspired Dental we are committed to providing you with the best possible care. This financial policy will allow us the opportunity to clarify any questions you have regarding payment for your treatment.

Initial

_____Your complete insurance information must be present at the time services are provided. Insurance claims cannot be backdated.

_____Your dental benefits are based upon a contract made between your employer and insurance company. If you have any questions regarding your dental benefits contact your employer, insurance company, or our office directly. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to receive prior authorization for any services, we will gladly submit the necessary paperwork. Keep in mind this is not a guarantee of coverage.

_____Claims for your dental care will be submitted on the day treatment is completed. In the event of your insurance carrier remits less than the estimated amount for the claim, for any reason inclusive of denied claims, the patient/responsible party is financially responsible to pay the unpaid balance.

_____ INSPIRED DENTAL DOES REQUIRE PAYMENT IN FULL FOR YOUR PORTION AT THE TIME OF SERVICE. We gladly accept MasterCard, Visa, American Express, Discover, cash, and checks. Checks over $500 must be paid at least 7 days prior to the day of service.

_____ If dentures, partial dentures, crowns and bridges are to be fabricated by a dental laboratory, a 50% down payment will be required at the time of the first impression. The remaining balance is due at the time prosthesis is cemented or inserted. If an appointment is two or more hours, the procedure must be pre-paid (minimally half down) in advance of the appointment.

____The parent that accompanies the minor child/ children under the age of 19 to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency services will be denied unless charges have been pre-authorized prior to service being completed.

____Checks that are returned to our office from your financial institution are subject to a $20.00 return check fee, this covers the processing fees that are charged to our office.

____ A specific amount of time is reserved specially for you and we strongly encourage all the patients to keep their appointments. If you must change your appointment, we will require at **least a 24 hour notice to avoid a $35/hour cancellation fee.**

____In the event of an emergency after regular business hours a **$75 emergency fee** will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged a **$125 after hour's emergency fee**.

___ I have read the financial policy. I agree with the above conditions.

Print Name: _____ Date: _____

Patient/Parent signature: _____