HUNTER ENDODOTICS FINANCIAL POLICY

We welcome all questions about procedures and fees.

FOR ALL PATIENTS ON DENTAL INSURANCE: This specialty practice is a participant in the Delta Dental network. We will submit your insurance claim as a courtesy and convenience to you, but we do not guarantee payment by your insurance carrier. **It is the patient's responsibility to understand the dollar limits and deductibles, and service or provider exclusions of that policy.** Please ask if you are unsure about your dental coverage and we will help with these questions to the best of our ability.

Because benefit checks from most carriers are sent to our office and usually cover 50 to 80% of the procedure fees, patients are asked to pay an estimated 20% of the procedure fee at the time of their appointment. **After insurance has made payment, any overpayment to your account will be refunded.**

Our minimum office visit (exam, x-ray and consultation) is $120.00. All patients, regardless of benefits they might receive, are asked to pay this fee at the consultation visit when a separate appointment has been used for these diagnostic services.

Payment arrangements are requested at the time of your visit. In an effort to provide you with flexible payment arrangements, we offer the following options:

Please make your selection for payment method, sign below and return to office staff.

- ☐ Cash payment in full (5% discount)
- ☐ Credit Card payment in full (Visa, MC, Discover, and debit card)
- ☐ Automatic monthly billing to your Visa, MC, or Discover card
- ☐ Payment of $250 (minimum payment for patients with insurance and guarantee any amount not covered by insurance with Visa, MC, or Discover Card

Patient Declaration: I authorize the assignment of insurance benefits for services rendered at this office to Dr. Stephen G. Hunter. I am responsible for amounts not covered by insurance and have made appropriate financial arrangements. I agree to be responsible for all fees associated with collection services for unpaid bills and bank fees for returned checks. Furthermore, I agree to pay all legal fees, court costs and other necessary expenses incurred in the debt collect process.

I have read, understand and agree to the office policy and financial terms.

X_____ Date_____

(*Signature of Financially Responsible Party*)