# Financial Policy and Assignment of Benefits

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. The following is a statement of our Financial Policy and an Assignment of Benefits. Thank you for your time in reading and understanding this important document.

**Regarding Payment**

We Accept the following forms of payment: Cash, Check, Visa and MasterCard. Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor or the billing receptionist. Checks that are returned to our office from your financial institution are subject to a $35.00 returned check fee.

**Regarding Insurance**

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract; however in most cases as a courtesy to our patients we will file your insurance claim. In the event we do accept assignment of benefits from your insurance company and your insurance company has not paid your account in full within 60 days, the balance then becomes your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services. Your insurance company may only pay for selected treatment or they may not cover any of the treatment provided to you. You are responsible for payment in the event your insurance company does not cover the complete cost of treatment provided to you.

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. We will do our best to verify your insurance benefits and provide you with an accurate estimate of your cost of treatment. However, please understand that this is simply an estimate and may change once final payment is received from your insurance company. As a courtesy we will file your insurance claim(s) with one insurance company. All insurance copays and deductibles must be paid at the time of service.

**Assignment of Benefits**

I hereby authorize and direct my insurance carrier(s) to issue payment check(s) directly to Bertram Dental for dental services rendered to myself and /or my dependents. I understand that I am responsible for any amount not covered by my insurance.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly at 512-355-2115 for assistance in the management of your account. Please let us know if you have any questions or concerns.

I have read the Financial Policy and Assignment of Benefits. I understand and agree to the Financial Policy and Assignment of Benefits.

Printed name of Patient or Responsible Party:_____

Signature of Patient or Responsible Party:_____

Date:_____