HAMBURG LASER DENTISTRY
DAVID T. BURNELL D.D.S.
OFFICE FINANCIAL POLICIES

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. The following is ***a statement of our financial policy*** that we require you read and sign prior to any treatment.

REGARDING INSURANCE PLANS WE DO PARTICIPATE WITH:

We require that all estimated co-pays and charges for non-covered services be paid at the time of service. There will be a 10.00 billing processing fee applied to your account for co-pays that are not paid at the time of service.

Since we are not a party to the agreement with your insurance carrier, it is NOT OUR POLICY to contact carriers to establish why they have not paid or why they paid less than originally indicated. *Please be aware that some and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary according to your insurance carrier.* If you are covered by an insurance plan, we will be happy to file the claims for you. However, the responsibility for payment will remain with you. For patients with large treatment plans, financial arrangements must be made with the business office prior to the start of treatment**. A finance charge of 18 % annually, or 1.5% monthly will be added to all unpaid balances**.
We provide evening and Saturday appointments for the convenience of families. Any appointment not cancelled within 24 hours will be subject to a 50.00 charge per person.

PAYMENT IS DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, CHECKS, DISCOVER, VISA, MASTERCARD, CARE CREDIT

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary in our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS

The adults accompanying a minor are responsible for full payment. For **unaccompanied minors, non-emergency treatment may be denied if parental consent to treat the minor does not accompany the patient.** Patient must also bring authorization for charges to an approved credit card or payment by cash or check at the time treatment is provided.

I have read the Financial Policy. I understand and agree to this Financial Policy.

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Signature of patient or Responsible Party Date