Endodontic Associates Financial Policy

We are committed to providing you the best possible care. If you have dental insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and you understanding of our payment policy.

We will be happy to process your claim for reimbursement. If we accept assignment of your insurance plan, you will only be required to pay an *estimated* co-pay and deductible, or percentage as stated by your insurance company. Payment for theses *estimated* charges is expected on date of service and is payable by Visa, MasterCard, Discover, American Express, check or cash.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however that:

1) Your insurance is a contract between you, your employer and the insurance company and we are not a party of that contract.

2) Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We will have no way of knowing how your insurance policy is written. All are different.

3) We cannot become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "Usual & Customary" charges, etc., other then to supply factual information as necessary.

We must emphasize that as a dental provider, our relationship is with you, the patient, and not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. It is to be understood that charges not payable by insurance are your responsibility and all charges are due in full within 90 days from the date-of-treatment regardless of insurance pending. We realize that temporary financial problems may affect timely payments on your account. If such problems do arise, we encourage you to contact our office promptly for assistance in the management of your account.

If you have any questions regarding the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

Patient's Name Printed: _____

Patient's Signature: _____

Date: _____

Please choose how you would like to pay today:

___ In full with a check or cash and save 5% (charges over 300.00)

___ In full with a credit card and save 3% (charges over 300.00)

___ My estimated co-pay based on the insurance plan I have

___ I have been pre-approved for a payment plan with Care Credit