TENNESSEE FAMILY DENTAL
FINANCIAL POLICY

Payment in full is expected when services are rendered. All other arrangements must be made prior to your appointment.

Insured Patients

- **Although your insurance may assist you with partial payment of your treatment, the estimated portion that is not covered, is due when services are rendered.**
- **As a courtesy to our patients, we will file your primary insurance for you. If your insurance has not paid within 60 days, you will be responsible for the entire unpaid balance and payment in full will be expected at this time. We will however, continue to work with you and your insurance company to expedite your reimbursement.**
- **Missed New Patient appointments must pay a deposit of $50.00 to reschedule the appointment.**

We do not accept assignment of benefits for secondary insurance, however, we will provide a claim form for you so that you may file and be reimbursed by your company.

Payment may be made by any of the following methods. Please indicate your method of payment below.

CASH _____ CHECK_____ CREDITCARD_____

Information is available upon request for third party financing through Care Credit.

- **I understand and agree that I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claim(s) by my insurance company.**
- **I agree to pay any and all unpaid balances on my account.**
- **I authorize all insurance benefits paid directly to Tennessee Family Dental.**
- **If payment by the insurance company is made to the insured, I agree to endorse or have the insured endorse the benefits check to Tennessee Family Dental, or make payment immediately to Tennessee Family Dental.**
- **I authorize the release of information to my insurance company, attorney or legal representative to obtain reimbursement of any claim(s) or for other reasons.**
- **A finance charge of 1.5% will begin to accrue after 60 days from the date of service on the unpaid balance of my account even though insurance may be pending.**
- **A fee of $40.00 will be incurred for each returned check.**
- **I agree to pay collection costs, attorney's fees, court costs, and interest from the date of treatment if this account is assigned to collection status.**
- **I authorize this office to discuss my account with a spouse or parent/step parent (if patient is not a minor but using parent or step parent insurance).**
- **Appointments of 2 hours or greater may require that the appointment is secured with a deposit equal to 50% of the anticipated patient responsibility.**
- **Saturday appointments are in extremely high demand. Last minute cancellations and no show appointments must be pre-paid to be rescheduled on Saturday.**
- **Missed hygiene appointments cannot be rescheduled on Saturday.**
- **I have read, understand, and agree to the above terms.**

I understand that I must give a minimum of 24 hours notice in order to cancel or reschedule an appointment. If I fail to keep an appointment without the necessary notice, I agree to pay $75.00 on the second offense. I understand that I may be released from the practice for a third offense.

_____ _____

Signature of Responsible Party **Date**