**Financial policies**

North Florida Dentistry accept several forms of payment for dental treatment provided by this office. **Cash, personal check, credit Cards, Care Credit, MasterCard, Visa, Discover and American Express.**

**Third Party Finance company:** We offer CareCredit and Alphaeon interest free financing to assist you in multiple monthly payments. Options for 6 & 12 months. The application process is easy and convenient via phone call or internet. This is a great opportunity to complete your dental treatment now!

**Dental Insurance:** Understanding your insurance coverage can be quite a challenge. Our goal is to provide reasonable assistance to help you maximize your benefits. Most dental insurance excludes coverage for some services, uses restricted fee schedules for most services, and can decline payment based on any number of policy restrictions and limitations. All such restrictions and limitations are based on the premium paid by your employer for the coverage, not on our fees or the treatment we recommend. We encourage you to become familiar with your policy: its coverage, exclusions, deductibles and maximums. **We recommend treatment appropriate to your dental needs regardless of your insurance status.**

**Our courtesy service to our patients includes:**

1. Filing your claim/s promptly and requesting that payment be sent directly to us.

2. Following American Dental Association guidelines for claims, coding, and filing.

3. Estimating your benefits to the best of our ability. Most insurance companies will not provide us with detailed information about your coverage, **so any insurance figures we provide you are only estimates.**

**Our expectations of you as the insured patient and/or owner of the policy**:

1. You are responsible for all fees not covered by your insurance company.

2. You will assume responsibility for any amounts expected from your insurance company, not received within 60 days after treatment had been performed and the claim submitted. Please understand that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance company.

3. You will pay any outstanding balances within 30 days upon receipt of statement.

I hereby authorize North Florida Dentistry to release any information acquired during my dental care to my insurance company. I authorize benefits to be paid directly to North Florida Dentistry. I understand I am responsible for all fees and/or contractual allowances incurred, regardless of the status of insurance.

I understand that if I hold an unpaid balance older than 90 days it will be placed for collections action.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Please Print)

Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Please Print)

Patient/Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_