*Springfield Smiles*
Christian A. Victor D.D.S.
413 E. Home Rd.
Springfield, OH 45503
937-390-3077

# Financial Policy

Thank you for trusting us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we ask you to read and sign prior to any treatment.

* FULL PAYMENT IS DUE AT TIME OF SERVICE
* WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AND CARECREDIT

## Regarding Insurance

If you have insurance which will cover the procedure performed and you provide us with complete and accurate insurance information, your estimated portion, based on co-payment, deductibles, UCR, and non-covered services, is due the day services are provided. If you do not provide insurance information necessary to submit your claim, you will be responsible for payment in full.

You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates or fee schedules.

When the insurance payment arrives in this office it will be applied to your account. If you have over-paid your estimated portion, a refund check will be issued to you at the end of the month in which we receive the overpayment. If your insurance company denies payment or there is a balance remaining on your account, you will receive a statement and you will be responsible for payment in full for the remaining balance.

If you are not satisfied with what your insurance company has paid toward your account, we will provide you with the information necessary to contact your insurance company concerning a review of the claim filed.

If the insurance check is mailed to you, it should be endorsed and immediately forwarded to the address listed above for payment toward your account balance.

In the event that this office needs to obtain legal assistance in the collection of any unpaid balance on your account, the undersigned agrees to pay all legal fees and reasonable court costs.

## Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge $25 for missed appointments. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. We appreciate the opportunity to serve you and will assist you with any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

X (To be signed electronically) Date (Filled in electronically)
Signature of Responsible Party

# Thank You