Springfield Smiles

Family Dentistry

Christian A. Victor, DDS

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. Alternatively, a financing plan is available.
* WE ACCEPT CASH, CHECKS, MONEY ORDERS, VISA, MASTERCARD, AND CARECREDIT

Help us keep your costs low: Please note a 4% processing fee will be added if payment is made with a credit card. Therefore, please consider alternative payment methods to avoid this fee.

Regarding Insurance: Most insurance companies offer multiple employer based programs. While our office may be a provider for your insurance company, we may not be for your particular employer program. It is your responsibility to verify with your insurance company that our office is a provider for your particular program.

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 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.

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.

Missed Appointments: Unless cancelled at least 24 hours in advance, our policy is to charge $45 for missed appointments. More than 3 broken appointments for the family/individual in a 12 month period may result in being dismissed from the practice. Please help us serve you better by keeping scheduled appointments.

Returned Checks: If by chance a check is returned as unpayable for any reason, our policy is to charge $25 to reimburse bank fees and handling charges. Personal checks will no longer be accepted for future payments once this has occurred.

Unpaid Balances: A $20 per month fee will be applied to any unpaid outstanding balance which has been billed but not paid within the initial 30 day grace period.

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Effective date: February 10, 2016

Collections: 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.

Authorization to accept Financial Responsibility for posterior composites (if applicable): Please understand that your insurance may reimburse posterior composites (white/tooth colored fillings) at the same rate that amalgam (silver) fillings are benefited for the same teeth. Therefore, if you elect to utilize composite posterior fillings, you agree to personally accept the additional financial responsibility between the benefited amount and the actual charge. Your actual cost will be determined by deducting the insurance reimbursement from the total fee charged.

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 _____ Date _____
Signature of Responsible Party