



Financial Policy

All co-payments, deductibles and non-covered services are due when services are rendered. If you have dental insurance, we will estimate your benefits to the best of our ability. However, as the patient or the subscriber, you are responsible to know your insurance benefits, exclusions and policy details. If you are insured by two carriers, we will collect the portion estimated not to be covered by the primary plan. Once the secondary plan pays their portion, we will then send a refund or credit your account. Hardin Cosmetic and Family Dentistry will not take responsibility if an insurance company does not pay for treatment. **We can only provide an estimate of benefits, not a guarantee of payment.**

All co-payments, deductibles and non-covered services are due when services are rendered. Prior to your dental treatment, we do our best to provide you with an estimation of your total investment. All, if any, financial arrangements or options are to be done before the treatment is rendered. Insurance companies have 60 days to make payment on a claim. Inquiries after this time become the subscriber's responsibility. Cash, Check, Visa, MasterCard, American Express, Discover and financing are all available.

I understand that I am financially responsible for all services whether or not paid by my insurance carrier. In the event that my account is not paid, I agree to pay all cost of collection, including attorney fees, court cost, any billing charges and interest fees.

Patient Signature: _____ **Date:** _____

I have read and understand the policy written above.

Guarantor Signature: _____ **Date:** _____

(if different from patient)

If you are going to be unable to keep your scheduled appointment time, we ask that you please have the courtesy to call the office at least 48 hours prior to the appointment. **Hardin Cosmetic and Family Dentistry reserves the right to charge a fee for any appointment failed or cancelled without a 48 hour notice.** A patient or family may be dismissed from the practice due to failed appointments or failing to keep account balances paid.

Assignment of Benefit Form:

I do hereby give permission to Hardin Cosmetic and Family Dentistry, to complain on my behalf, to the insurance commissioner and to my insurance carrier for delaying of any payment on my claims. I understand that by law, my insurance company is required to pay promptly and can be held accountable for not doing so.

Patient Signature: _____ **Date:** _____