PLEASE READ AND SIGN THIS FORM BEFORE RETURNING IT TO THE FRONT DESK

DENTAL SOLUTIONS- DR. ERIC C. WEISS, DMD

Payment Policy

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

All patients must complete their information before seeing the doctor. We are now participating with Cigna, Delta Dental, Dentemax and United Concordia. If we do not participate with your insurance plan, **Full payment is due at the time of service**. We accept cash, checks, Visa, MasterCard and Discover. We will submit a claim to your insurance carrier for you. Your carrier will reimburse you directly.

In the event your insurance coverage changes, it is your responsibility to make us aware of this change and provide us with the new card/information.

We will do our best to give you a rough estimate of your investment in your dental health for each upcoming visit, based on your individual treatment plan. You will be given a very close estimate of your next visit's total bill. Most estimates we provide are accurate.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. YOU ARE RESPONSIBLE FOR PAYMENT REGARDLESS OF ANY INSURANCE COMPANY'S ARBITRARY DETERMINATION OF USUAL AND CUSTOMARY RATES.

Outstanding balances on your account are discouraged, and must be cleared before the next appointment for any account member or within 30 days of treatment, whichever comes first. Appointments for non-emergency treatment may need to be postponed pending payment of outstanding balances. Amount due and not paid in full within 30 days will be charged interest at a rate of 1.5% per month.

Delinquent balances over 60 days old will be referred to a collection agency. All referred accounts are marked "inactive". If your account becomes assigned to a collection agency, you will be responsible for a 25% collection fee, interest in the amount of 18%, court costs, attorney fees, as allowed by law.

Minor Patients

The adult/parent/guardian accompanying a minor is responsible for full payment at the time of service and for future treatment. This is our policy regardless of divorce/separation and court-mandated designation of responsible party. We are not a party to any such order of the court. Our relationship is established with you.

Miscellaneous

There will be a $40.00 charge for all failed appointments if we do not receive 24 hour notice of your appointment being canceled.

There will be a $35.00 fee for all checks returned unpaid by the bank.

I HAVE READ, UNDERSTAND AND AGREE TO THE POLICY.

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Signature of Patient and/or Guardian (SEAL) Date