Meadows
FAMILY DENTISTRY
PRESTON H. POLSON, DDS

OFFICE HOURS:

Monday-Tuesday 8AM-5PM
Wednesday: 7AM-3PM
Thursday: 10AM-6PM
Friday: 7AM-1PM

FINANCIAL POLICY

We at Meadows Family Dentistry would like to welcome you to our practice. Dr. Preston H. Polson believes in creating vibrant and healthy smiles using the most advanced quality dentistry to exceed the patients' expectations. Beginning with the overall health of your mouth, we can provide you with the smile that you have always dreamed of having. We would like to provide you with information to make your experience more comfortable.

This is an agreement between Preston H. Polson, DDS, and/or Meadows Family Dentistry, as creditor, and the Patient/Debtor named on this form. In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name, to which charges are made and payments credited. The words "we", "us", and "our" refer to Preston H. Polson and/or Meadows Family Dentistry.By executing this agreement, you are agreeing to pay for all services that are received.

INSURANCE: Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract. We will be happy to file your insurance and accept assignment of benefits. **However you are ultimately responsible for all charges that are incurred. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.** We will do our best to facilitate payment from your insurance company. We request that you pay your estimated patient portion at the time of service unless prior financial arrangements are made.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, ***the finance charge, or late charge, if any***, and any payments or credits applied to your account during the month.

PAYMENT OPTIONS IF YOU DO *NOT* HAVE INSURANCE:

1. You may choose to pay with CASH, CHECK, or VISA/MASTERCARD on the day that services or treatment is rendered.
2. On extensive treatment, you may prefer to secure a bank, credit union, or other third party financing for the entire amount and make payments to the lending institution.
3. We offer special financing with 6 months or 12 months zero percent interest through *Care Credit.*

PAYMENT OPTIONS IF YOU *DO* HAVE INSURANCE:

1. You choose to pay your deductible and any out of pocket portions at the time services are rendered by CASH, CHECK, VISA/MASTERCARD, or *Care Credit*.
2. You choose to pay the cost for your entire treatment or services by CASH, CHECK, VISA/MASTERCARD, or Care Credit. We will request that your insurance carrier send their payment directly to you.

Meadows
FAMILY DENTISTRY

PRESTON H. POLSON, DDS

PAYMENTS: Unless other arrangements are approved by our office in writing, the balance on your statement is due and payable by the end of the month in which the statement is issued and is past due if not paid by the end of the month.

A late/ past due fee of $25.00 will be imposed on all accounts that are <u>not paid in full</u> by 30 days from the date that the statement is issued.

REQUIRED PAYMENTS: Any co-payments required by your insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

RETURNED CHECKS: There is a fee of **<u>$75.00</u>** for any checks returned by the bank. This fee is subject to change without notice.

PAST DUE ACCOUNTS: If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the costs of collecting the debt which is owed to our office. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur, plus any court costs.

WAIVER OF CONFIDENTIALITY: You understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

DIVORCE/ SEPERATION: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After divorce or separation, the parent authorizing treatment for a child will be the person responsible for those subsequent charges. If the divorce decree requires the other parents to pay all or part of the treatment costs, it is the authorizing parent who is responsible to collect from the other parent.

TRANSFERRING OF RECORDS: You will need to request in writing and pay any applicable fees if you want to have copies of your records or x-rays sent to another Doctor or Organization.

FAILED AND BROKEN APPOINTMENTS: Each appointment is made especially for you; we try to accommodate your schedule by giving you a choice of appointment times. We respect your busy schedule by seeing and finishing your procedures in a timely manner. We ask that you give us 24 hours notice to cancel or make changes to your appointment. **If you are more than10 minutes late to your scheduled appointment time**, we reserve the right to reschedule your appointment and assess the broken appointment fee of $50 per hour that was scheduled for you, as well as collecting the estimated cost for the appointment ***prior*** to scheduling any future appointments.

A charge of $75.00 <u>per hour reserved</u> for your appointment will be billed in the event of a failed or broken appointment that was not cancelled 24 hours prior to the appointed time.

PRODUCTS PURCHASED IN OFFICE: Any products that are purchased at Meadows Family Dentistry (ie: Rotadent Toothbrush, prescription mouth rinse or prescription toothpaste cannot be returned once they have been opened or the seal has been broken.Our staff will be more than happy to answer any other questions that you may have.

Sincerely,

Preston H. Polson, DDS

_____ Signature of Patient or Guardian