Michael S. Page, DDS

Page Family Dentistry
– SOMETHING TO SMILE ABOUT –

Andrew T. Crist, DDS

FINANCIAL POLICY

Thank you for choosing us as your dental 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 financial policy which we require that you read and sign prior to any treatment.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office will file your insurance claims and can provide other services, including a pre-treatment estimate which we can send to the insurance company at your request. It is up to you as the patient to contact your insurance company and inquire as to the specifics of your benefits. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Pre-treatment estimates are only an estimate and may not accurately reflect the final payment due. Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

APPOINTMENT CANCELLATION:

To ensure efficient scheduling, we will charge our standard missed appointment fee for any missed appointment that is not cancelled within 24 hours notice by phone call or text. This fee must be paid prior to the time of your next scheduled appointment and will apply to all appointments, including dental cleaning visits and dental procedures.

PAYMENT:

Payment is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service. If insurance benefits do not apply, full payment is due at the time of service unless other arrangements are made.

UNPAID BALANCE over 60 days old will be subject to a monthly interest of 1.5%. If payment is delinquent, the patient may be sent to collection agency and the patient will be responsible for payment of collection agency fees, attorney's fees, and/or court costs associated with the recovery of the monies due on the account.

PAYMENT OPTIONS we accept include cash, check, and credit card (Visa, Mastercard, American Express). We offer a 5% savings benefit for payments made in full at the time of treatment.

Signature of this agreement is a requirement to be a patient at our office. By singing this agreement:

- I agree to pay the all amounts charged by Page Family Dentistry for all professional and dental treatment and services. All remaining balances not covered by my insurance are my responsibility to pay in a timely manner. If I am designated as the responsible party for others on my account, I agree

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to pay all fees charged for their services. I agree to pay any finance charges, missed appointment fees, and collection agency fees, that are charged to my account. Payment to be made to Page Family Dentistry, 107 E Locust Street, River Falls, WI, 54022.

- I authorize Page Family Dentistry to furnish to my dental or health insurance company all of the information which said company may request concerning treatment for myself, my dependents or other individuals listed under the responsible party on my account.

- I assign to Page Family Dentistry the dental and/or medical/surgical benefits to which I or my dependents are entitled under my dental or health insurance. I understand that I am financially responsible for all charges on my account. I acknowledge that Page Family Dentistry may give me an estimate for services, that estimate amount is solely an estimate and may not accurately reflect the final payment due, and that I am responsible for the final payment due. I acknowledge that it is my responsibility as the patient to confirm the exact benefits directly with my insurance company.

- I agree to make payment in full for all charges within 45 days of services unless a written financial agreement has been made in advance.

- Patient Name: _____ Date:_____

- Signature: _____