Financial Policy of Lake Mary Dental

As a courtesy to our patients, Lake Mary Dental will submit all dental claims to your primary insurance company. If claims are not paid by the insurance company for any reason, it becomes the responsibility of the patient or guardian (if the patient is a minor). Prior to submission of claims the patient/guardian will be thoroughly informed of all procedures, options, and estimated cost before starting treatment. Please be advised that treatment is determined by what is deemed necessary by your dentist, not by what your insurance covers. Should you have any questions or concerns, please feel free to address them with us.

We will estimate a **"patient portion"** based on the insurance information you have provided. It is our policy that the **"patient portion"** is to be paid in full at the time the procedure is scheduled. We will then file the claim with your insurance company. If insurance pays more then the estimated cost, we will credit your account or issue a refund for the difference. If the insurance company pays less than the estimate, you agree to pay the difference within 15 days of notification. If for any reason insurance payment is delayed for more than 60 days after submission, you agree to pay the entire balance within 15 days of notification.

Full payment is required to reserve appointments. The payment will be applied towards treatment.

All fees charged are the sole responsibility of the undersigned. Any balance outstanding beyond 30 days is subject to a 1.5% service charge (18% APR) with a minimum monthly service charge of $1.50. A late charge fee will b assessed on any payment received 10 or more days after the due date. Returned checks will be charged $25 or 10% of the check amount- whichever is greater.

_____ (Initials)

The undersigned agrees to pay all reasonable attorney fees, court costs, and collection fees should collection activity become necessary. If this account is assigned to a collection agency, an additional fee of 40% of the outstanding balance will be added to the account.

I have read and understand Lake Mary Dental's Financial Policy.

_____ _____

Print Name Date

_____ _____

Signature Date