Financial Policy

Thank you for choosing the office of Lakeland Creek Family Dental for your dental health needs. We are committed to providing you with the highest quality dental care, so that you may fully attain optimum oral health throughout your life. Please understand that your bill is considered part of your treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available upon request and approval. Please ask if you would like more information about financing options.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred. The minimum charge for a collection service and/or legal assistance is 35% of uncollected charges.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, or with the patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- 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 if any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- At the time of service we ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, or Discover.
- Insurance payments are ordinarily received within 30-60 days from time of filing. If your insurance company has not been made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.
- If you do not wish to have our assistance with your insurance claims, you may choose to pay at the time of service and submit the insurance claim yourself. Talk to our office manager if this is your desire.

We thank you for the opportunity to serve your dental health needs and welcome any questions you may have concerning your care or our financial policy.

CONSENT:
The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk. I understand that the responsibility for payment for Dental Services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, re-billing, collection charge or attorney fee will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

Patient Signature (Parent of Child)_____ Date_____