DESCHUTES DENTAL CENTER

PHILLIPPE C. FREEMAN, D.M.D.

FINANCIAL POLICY ACKNOWLEDGEMENT

As a service to our patients, our office will submit charges for dental treatment to the patient's insurance carrier when all current dental insurance information is provided and copied in the office. However, ***payment for professional services is the responsibility of the patient. Dental treatment is not provided on the assumption that the charges will be paid by an insurance company.*** Major services can be pre-authorized in advance when requested. The patient is then expected to pay their portion of the estimated cost of treatment by the final appointment. Our office advises that each patient become familiar with their insurance coverage as dental insurance is not designed to cover every type of treatment available, but rather a range of services most commonly provided. Our staff can assist you in defining your benefits.

As a courtesy, our office will submit claims for treatment resulting from on the job injuries or motor vehicle accidents when proper forms are provided, but the patient is responsible for payment of these services by the completion of treatment. Should worker's compensation or auto insurance make their payment to this office, a refund will be issued to the patient.

This practice has been dedicated to providing a higher standard of dental care. While providing that service we do not cut corners or utilize inferior materials or techniques.

Our commitment is to your oral health and well-being. In order to continue that trend, we have removed ourselves from the business of extending lines of credit and insist upon financial arrangements that allow the practice to maintain its expenses and quality of care.

We reserve the right to charge a 1.6% monthly fee for any account over 60 days. Our office also offers financing through a dental financing program (ask us about it). ***Even if dental insurance applies to you any balance over 60 days becomes the patient's responsibility even if the applicable insurance has yet to pay. All account balances are ultimately you, the patient's responsibility to pay promptly***.

All out of state and emergency patients are expected to pay at the time of service.

CONTRACTUAL AGREEMENT TO PAY DENTAL EXPENSES

Cancellation Policy: ***There will be a room set up fee beginning at $50 per hour if an appointment is cancelled with less than 48 business hours notice.*** Shorter cancellation notices or changes severely limit our ability to continue to provide services efficiently with reasonable fees due to losses incurred by last minute cancellations. Please remember this time is reserved exclusively for you and your courtesy may allow someone else to be seen in a timelier manner.

I understand that I am personally responsible for all dental expenses incurred at the office of Phillippe C. Freeman, D.M.D even if I have dental insurance. I agree to pay all dental expenses as set out above even if my insurance does not pay promptly.

I authorize release of records to my insurance company as needed and authorize payment of insurance benefits to Phillippe C. Freeman, D.M.D.

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Patient's Signature (Parent or Guardian in case of minor) Date of Signature