

APEX ENDODONTICS FINANCIAL POLICY

Payment in full is expected when services are rendered. All other arrangements must be made prior to your appointment.

Insured Patients

- Although your insurance may assist you with partial payment of your treatment, the estimated portion that is not covered is due when services are rendered.
- As a courtesy to our patients, we will file your primary insurance for you. If your insurance has not paid within 60 days, you will be responsible for the entire unpaid balance and payment in full will be expected at this time. We will however, continue to work with you and your insurance company to expedite your reimbursement.

We do not accept assignment of benefits for secondary insurance, however, we will provide a claim form for you so that you may file and be reimbursed by your company.

Payment may be made by any of the following methods. Please indicate your method of payment below.

CASH_____

CHECK_____

CREDIT CARD_____

Information is available upon request for third party financing through the following:

Care Credit

- I understand and agree that I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claim(s) by my insurance company.
- I agree to pay any and all unpaid balance on my account.
- I authorize all insurance benefits paid directly to Apex Endodontics.
- If payment by the insurance company is made to the insured, I agree to endorse or have the insured endorse the benefits check to Apex Endodontics or make the payment immediately to Apex Endodontics.
- I authorize the release of information to my insurance company, attorney or legal representative to obtain reimbursement of any claim(s) or for other reasons.
- A finance charge of 1.5% will begin to accrue after 60 days from the date of service on the unpaid balance of my account even though insurance may be pending.
- A fee of \$37.00 will be incurred for each returned check.
- I agree to pay collection costs, attorney's fees, court costs, and interest from the date of treatment if this account is assigned to collection status.
- I have read, understand, and agree to the above terms.
- I authorize this office to discuss my account with a spouse or parent/step parent (if patient is or is not a minor but using parent or step parent insurance).

Signature of Responsible party

Date