Financial Policy and Insurance Guidelines
for Rock 'N' Roll Dental, Ethan Harris DMD, INC.

We are committed to providing the best quality Dental Care that is affordable, in a comfortable clean environment. In order to do so, we need your partnership and your clear understanding of our financial policies. Therefore, we ask that you read and understand the following:

If you have insurance there is a unique contract between you, your employer and your insurance company. Not all services are covered by all insurance plans and the percentage of coverage varies significantly based on the contracted benefit the company has established. Insurance coverage allowances should not be confused with the doctor's determination of which services are necessary and appropriate for your best care. The doctor has a dental care relationship with you, separate form any contractual agreements with insurance companies. Because you are the recipient of services, all charges are your responsibility. Initials_____

We may or may not participate in the contractual arrangement with your insurance company; however, we do accept insurance and want to help you receive the maximum reimbursement to which you are entitled. As a convenience to you, we will help you process your insurance claims in order for you to receive this maximum benefit. We will investigate, process, and follow up on your insurance benefits so you can minimize your inconvenience and out-of-pocket expenses. Every policy is different and we do not have access to every detail of every policy. It is in your best interest to know and understand your benefits, deductibles and co-payments before you seek services.

Initials_____

We will collect your estimated portion at the time of service and bill your insurance for their estimated reimbursement portion. We do not receive a guarantee of benefits from your insurance company.
If there is a balance remaining after the insurance portion is paid or denied it is due within 30 days. A service charge of 1.5% (18% annual) on the unpaid balance will be charged on all accounts exceeding 30 days including balances billed to insurance. Any accounts past due over 90 days may be sent to a collection agency. Collection fees will apply. Initials_____

We understand that temporary financial challenges do arise and may affect timely payment of your account. If such a problem occurs, please contact our office promptly to make arrangements. Please remember you are fully responsible for all fees charged by this office regardless of your insurance coverage. We will bill your insurance for services only if you have supplied us with your current, complete and verifiable information. Please advise us of any changes. Initials_____

Payments need to be made at the time of service. For your convenience we accept most major credit cards and ATM cards. In special circumstances we can make payment arrangements, but this needs to be arranged prior to services rendered. Fee estimates are valid for 3 months from the date of the treatment plan.

Initials_____

Cancellation and Rescheduling Guidelines

We thank you for choosing our practice and want to spend quality time with you. Because we want to provide you with the highest quality of care possible, by seeing one patient at a time, we ask that you schedule your appointments at a time when you can keep the commitment. We understand that circumstances do come up that require you to reschedule your appointments on occasion. We require two business days (48 hours) notice to cancel or change an appointment. If you are unable to give us this advanced notice, there will be a $120.00 charge. For the first violation, you will be sent a policy reminder letter. The second violation will add the $120.00 charge to your account. After the third violation, in addition to another $120.00 charge, we will require pre-payment for all future appointments which is non- refundable should you miss your appointment or reschedule with less than 48 hours notice. Initials_____

I have read the above conditions for treatment, payment, rescheduling, and agree to the content.

Patient Signature_____Date_____

Parent, if the patient is a minor_____