

Thank you for choosing Dr. Eades as your dental health provider. Our office is committed to providing you quality treatment. Please understand that payment of your bill is considered part of your treatment. Prior to any treatment, we ask that you read, agree to, and sign this Financial Policy below and complete our Patient Information Sheet.

FINANCIAL POLICY

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, checks, and Visa/MasterCard/American Express/Discover. Should you desire a payment program ask how Care Credit can benefit you. The parents/guardians of a minor patient are responsible for full payment on behalf of the minor at the time of treatment.

INSURANCE

Your insurance coverage and policy is a contract between you and your insurance company; however, we agree to submit on your behalf, our billing statements to your insurance company. To do this we must have your complete insurance information. The benefit information we may provide is not a guarantee of benefits or payment is subject to the final approval of your insurance carrier.

You are responsible for co-payments, deductible payments and any other payments deemed your responsibility. In the event we do not receive payment from your insurance company within (60) days of the date services are rendered, the outstanding amount owed will be automatically deemed your full responsibility and payment will be expected immediately upon notice of these circumstances to you.

I have read and I understand this Financial Policy and agree to its terms.

Patient

_____ Date

Parent/Guardian (if patient is a minor)