TOMKO DENTAL
ASSOCIATES

Financial Agreement

Payment

Payment of **estimated** patient portion is due at the time of treatment. We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options:

1. We accept the following forms of payment: Cash, Check, Visa, MasterCard, and American Express.
2. Flexible payment plans of up to 12 months upon approval with Care Credit ®. Approval must be received prior to treatment date (24 months for Clear Aligner Therapy).

Payment for services is due at the time services are rendered unless prior arrangements have been made with the treatment coordinator.

If dentures, partial dentures, crowns and/or bridges, retainers, mouth guards or night guards are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.

The parent that accompanies the minor child/ children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the treatment coordinator.

Checks that are returned to our office from your financial institution are subject to a $35.00 returned check fee. This fee covers the processing fees that are charged to our office.

Regarding Insurance

As a courtesy to you we will gladly process your insurance claim forms for in and out of network patients. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services.

We understand insurance guidelines can be difficult to understand and overwhelming at times. Fortunately with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company make the final determination once treatment is completed and the claim is submitted. Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility. All insurance co-pays and deductibles must be paid at the time of service. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account.

Out of network Patients: For patients with out of network insurance, we will still file your claim with your insurance company. However, payment for services rendered is due at time of service. Reimbursement from your insurance company will be paid directly to you and determined by your insurance's contract rate for out of network providers. In the unlikely event our office receives the reimbursement payment from your insurance company we will process it accordingly and determine if any refund to you is necessary. The refund will be issued in a timely manner in the original form of payment.

All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I realize I am financially responsible for all the charges incurred, regardless of insurance coverage. I am aware past due accounts will be subject to charge of 1 ½% per month interest. I am responsible for all collection costs incurred by the dental office.

Regarding Appointments

Your deserved time in our office is important. We understand that sometimes it is necessary to change your appointment so we ask that you kindly give us a minimum of 48 hours' notice. Without this notice, we are unable to offer treatment to other patients that may have needed our care. If 2 or more appointments are broken in a 12 month period without 48 hours' notice, a cancellation fee of $50 will be applied to your account, and if necessary, all future appointments will be cancelled and patients will be place on a "priority list" for their next visit.

Thank you for understanding our Financial Agreement. Please let us know if you have any questions or concerns.

I have read the Tomko Dental Associates Financial Agreement. I understand and agree to this Financial Agreement.

Signature of Patient/Responsible Party: _____ Date: _____