London bridge smiles

A Division of Atlantic Dental Care, P.L.C.

FINANCIAL POLICY

Thank you for choosing London Bridge Smiles for your dental healthcare facility. We are committed to providing you with the best dental care resources available. In our ongoing process to make sure that all your dental needs are met, our billing department can discuss our fees and this policy with you should you need additional information.

We ask that all responsible parties read and sign our financial policy as well as complete and sign the patient forms prior to any services being rendered.

In order to serve you better, we accept cash, check, Visa, MasterCard, Discover, American Express, and Care Credit.

We ask you pay a portion of your treatment in order to schedule and hold your treatment appointment. Payments for all services will be due in full at the time services are rendered. As a courtesy, we will be happy to bill your insurance carrier, although you are ultimately responsible for the entire bill.

As the responsible party please understand the following:

READ AND INITIAL:

_____1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with YOU, not your insurance company. We will supply only factual information to facilitate the claim process. We can do nothing about disputes over deductibles, co-payments, covered services, secondary insurances, "usual and customary charges", termination of coverage, or yearly maximums met.

_____2. All charges are your responsibility whether your insurance company pays or does not. If your insurance company does not remit payment within sixty days the balance will be due in full. If your insurance company remits any payments to you directly billed by London Bridge Smiles, you recognize an obligation to remit payment over to us immediately. (Failure to do this is considered insurance fraud)

_____3. I understand that fees for services, which include unpaid balances, deductibles and co-payments are due prior to scheduling future appointments.

_____4.I understand that a $25.00 fee for returned checks and unpaid balances may be subject to collection placements, collection fees, accrued interest, and attorney's fees (33% at the time of placement).

_____5. I understand that if payments are 30 days a 2% finance charge per month or a $10.00 late fee which ever is higher.

_____6.I agree to be responsible for payment of all services on behalf of my dependents.

_____7. **I understand that if I fail to make a scheduled appointment for myself or dependents without giving two of our business days notice (Monday through Thursday). London Bridge Smile reserves the right to charge me for the lost time at a rate of $50.00 for each hour of an appointment. I will be responsible for paying for these charges.**

At London Bridge Smiles we encourage you to communicate with us if you have concerns or problems meeting your financial obligations, so that we may assist you in keeping your account in good standing. I understand the above information and will be responsible for the patient listed below.

PATIENT'S PRINTED NAME _____ DATE _____

Signature of Patient or Responsible Party_____ DATE _____