Rolla Family Dentistry Financial Agreement

I have the financial responsibility to pay for services at Rolla Family Dentistry. I understand that my insurance determines the fees and may provide coverage for these services, but I am responsible to pay for all fees associated with evaluation and treatment if they do not pay. If Rolla Family Dentistry participates with your insurance plan, Rolla Family Dentistry will file your insurance for you with any copay/deductible due from you to be paid at the time of service. I will be responsible for payment of my annual insurance deductible, co-insurance and co-pays as required by my insurance plan. If Rolla Family Dentistry does not participate with my insurance plan, I understand that I am financially responsible to pay for all charges and understand that Rolla Family Dentistry will ask for payment in full at the time of service and file my insurance as a courtesy with any reimbursement sent to you.

Initials: _____

I agree to allow information to be forwarded to allow payment. I request that payment under my dental insurance plan be made to Rolla Family Dentistry or the provider named on the bills for services furnished to me and authorize Rolla Family Dentistry to release to the Social Security Administration, insurance clearinghouses or insurance companies any information needed to allow this claim to be paid. I permit a copy of this authorization to be used in place of the original.

Initials: _____

I assign all insurance payments to Rolla Family Dentistry. I assign all payments for services at Rolla Family Dentistry, including private insurance and any other dental plan to Rolla Family Dentistry. If my insurance sends me payment for services at Rolla Family Dentistry, I agree to endorse the check and send it along with a copy of the explanation of benefits to Rolla Family Dentistry immediately. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Initials: _____

Non-covered services are my responsibility to pay. Certain dental plans may not cover some exams or services. Those non-covered services will be my responsibility to pay. Rolla Family Dentistry can assist, but I understand that I am responsible for knowing the specifics of my dental insurance coverage. Please remember that your insurance company determines which services are covered, not Rolla Family Dentistry.

Initials: _____

I am responsible to know my insurance plan. I understand that it is my responsibility to understand my insurance policy's provisions including what services are covered, the need for referral, the yearly maximum, the deductible, the co-insurance or co-payments that may apply. I understand that co-payments and co-insurance are due at the time of service. I understand it is my responsibility to update Rolla Family Dentistry of any changes to my insurance.

Initials: _____

I am responsible to update insurance information with Rolla Family Dentistry. I will bring my current insurance card for each visit, and if I fail to update information, I will be responsible to pay any outstanding balance not covered by a new insurance plan.

Initials: _____

If my check has insufficient funds, I agree to pay a $25 fee and will be expected to pay with a valid form of payment and not a check. Payment can then be made with cash, credit or debit card.

Initials: _____

If I do not show up for my scheduled visit without calling at least a day in advance, I agree to pay a $25 fee.

Initials: _____

Financial responsibility for minors: Adults accompanying children or requesting services are responsible for payment, regardless of who has custody or who carries the insurance on the patient.

Initials: _____

Acknowledgment of Rolla Family Dentistry financial agreement and patient financial responsibility

Signature: _____ Date: _____

Name (print): _____