Patient Financial Policy

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your dental insurance carrier, full payment is due at the time of service. For your convenience we accept VISA, MasterCard, and Discover.

Your Insurance

- We have made prior arrangements with many insurers and dental plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the remaining amount at the time of service. This office's policy is to collect this payment when you arrive for your appointment.

- I realize that my benefits are subject to my insurance policy plan, provisions, exclusions, and limitations. The amount that I am asked to pay at time of surgery is an estimate only. I will pay the difference or receive a refund for any amount of my bill that my insurance does not cover. If my insurance company does not pay their part of my bill within 90 days, I will pay the entire amount and file against the insurance company myself. I hereby authorize payment of the medical or dental benefits otherwise payable to me by my insurance company directly to Dr. Flaggert.

- In the event that your dental plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

- I understand that I will be legally responsible for all collection costs, including interest charges, involved with the collection of this account if I default on this agreement.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

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Printed Name of the Patient

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Signature of Patient or Responsible Party if a Minor Date