CYPRESS DENTAL

Patient Name: ___________________________________

Account #: ______________________________________

Thank you for choosing Cypress Dental as your dental care provider. We are committed to quality patient care. The following is a statement of our financial policy, which we want you to fully understand prior to treatment.

FINANCIAL POLICY

Please understand that payment of your bill is considered a part of your treatment plan. If you are unable to pay in full today, please inform the front desk personnel so that we may discuss the financing options available to you. **UPON CREDIT APPROVAL, YOU MAY BE ELIGIBLE FOR AN AVAILABLE PAYMENT PLAN. WE ACCEPT CASH, CHECKS, AND MOST MAJOR CREDIT CARDS. FULL PAYMENT IS DUE AT THE TIME OF SERVICE.**

REGARDING INSURANCE

We may accept assignment of insurance benefits on your first visit to Cypress Dental. This means that your insurance company is expected to pay in full for your services that day. **HOWEVER, YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE HAVE NO CONTROL OVER THEIR DECISIONS AND THE AMOUNT THAT THEY DECIDE TO PAY.** Any unpaid balance for services received is your responsibility.

Before filing a claim on your behalf, we will attempt to verify coverage and calculate your deductible and co-payment as accurately as possible and provide you and provide you with estimated out of pocket cost. **ALL DEDUCTIBLES AND C0-PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.**

You should be aware that your insurance company will not guarantee payment over the telephone. We will not know the exact amount they will pay until they respond to the claim. **REGARDLESS OF WHAT YOUR INSURANCE COMPANY DECIDES TO PAY, YOU REMAIN FULLY RESPONSIBLE FOR THE PAYMENT OF YOUR BILL.** Once payment is received on your claim, we will send you a bill for any balance on your account.

I have read and understand the above Financial Policy. By signing below, I acknowledge responsibility and agree to the terms as written above.

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Signature of responsible party   Date