**HEIN DENTAL, PROFESSIONAL L.L.C**

**FINANCIAL POLICY**

- I understand that all responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at time of services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% finance charge(18% APR) may be added to my account.
- I understand that my insurance coverage is a contract between my employer and the insurance company. Not all services are a covered benefit. Some insurance companies arbitrarily select certain procedures they will not cover. We must emphasize that as dental care providers, our relationship is with you and not your insurance company. Filing your insurance claim is a courtesy we extend to all our patients.
- I understand your office can make no guarantee of any estimated coverage of payment by my insurance company. In the event my insurance does not pay with in 45 days from the date claim is submitted by Hein Dental, Professional L.L.C, I will be responsible for the total obligation.
- I understand Hein Dental, Professional L.L.C offers many forms of payment. All major credit cards are accepted. We offer financing through Care Credit (WAC).
- I understand that in the event my account would need to be sent to an outside collection agency, a 30% collection fee of the balance will be added to the account prior to assignment.
- I understand that if I elect not to provide my social security number, no credit exceptions can be exercised and all payments will be due in full at the time of service.
- I understand that my appointment time has been especially reserved for me, and in the event that I need to reschedule, I will give a 24-business hour notice. Failure to do so will result in a cancellation fee.
- I understand that it is my responsibility to advise this office of any changes in the information I provide regarding my insurance, patient information, or health history.
- I understand that fees are applicable for dental records and/or copies of dental x-rays.
- I understand that there will be a $25.00 insufficient funds fee added to my account in the event of a returned check.

Patient Signature_____Date:_____

Parent or Responsible Party:_____Relationship_____