# Stanford Dental

(636) 256-3559

## FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of receiving your treatment. The following is a statement of our financial policy, which we ask that you read, agree to, and sign prior to continuing treatment.

**Do You Have Insurance?**

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.

- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.

- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

- We ask that you sign this form and/or any other necessary documents (i.e. student status, coordination of benefits, etc.) that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover, American Express, or financing through CareCredit at the time we provide the service to you.

- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

**Please note:** We respect that your time is valuable and therefore we are committed to running on time at Stanford Dental. Each patient is given appointments that are exclusively reserved for that patient. To honor our commitment to run on time we ask that our patients arrive on time for their reserved appointments. Each of us has a part to play in the delivery of your dental services; on-time arrival allows us to ensure that you get the highest quality dentistry.
A fee of $50 is charged for the first offense and $100 for the second offense for patients who miss or cancel more than 1 time in a calendar year without 2 business days notice. Dr. James Stanford charges $35 for returned checks. All account balances 90 days overdue will incur interest at a rate of 18%. In case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your treatment plan, care, or our financial policy. If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you need.
I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

______________________________________ ______________________________
Patient Name (Please Print) Date

Signature of Patient (Guarantor, if Minor) ______________________________________________________________