# Financial Policy and Agreement

The goal of Belmar Smiles is to provide exceptional customer service and excellent dental care with both a professional and personal touch. In order to do so, we want to make certain that our financial policies are clear and understood by our patients.

If you have dental coverage, we will make a good faith estimate of your benefits and defer billing you for that amount **up to 60 days**. We will file the appropriate claim forms with your benefit carrier, provided that you provide us with your personal information including social security number, date of birth, and pertinent coverage information. We will also assist you in understanding your dental plan benefits.

If your benefit carrier denies coverage, or if we otherwise do not receive payment within **60 days** from the date services are rendered, the amount will then become due and payable by you. Please remember that your coverage is a contract between you and your benefit carrier and/or your employer and your benefit carrier. Although we will make every effort to help you obtain your benefits, we cannot guarantee your carrier will pay.

## Your payment is due at time of service

Fees for treatment are due at the time treatment is rendered after deduction of your good faith estimate of dental benefits as described above.

**Payment Options:** Cash, Check, Check Card with Visa Logo, Visa, MasterCard, Discover, American Express, Money Order, CareCredit, and Chase Health Advance

## Patient Responsibility

I acknowledge my responsibility for payment of services rendered by Belmar Smiles in accordance with Belmar Smiles fees and terms. I understand my responsibility is not modified by whether any third party (dental benefit carrier) pays for all, part, or none of the charges. If the balance on my account is not paid within **30 days** of my statement, a service charge will be applied to my account. If my account becomes delinquent, it may be forwarded to a third party collection agency. If this becomes necessary, additional fees may be added to cover handling charges.

**Signature**_____ **Date**_____

## Assignment and Release

I authorize payment to be made directly to Belmar Smiles by my dental benefit carrier. I accept financial responsibility for all services not covered by my benefit carrier and I authorize release of any dental care information requested by my dental carrier. This agreement becomes effective the date the patient begins his/her first visit with Belmar Smiles.

**Signature**_____ **Date**_____

# Cancellation Policy

At Belmar Smiles, we recognize that in today's busy world, adhering to a schedule is important in order to maximize time and meet the demands of daily life. With this in mind, we have developed a cancellation policy that is fair to both our patients and our practice.

We are committed to seeing our patients on time and respecting their time. Cancellations (less than 48 business hours notice), failed appointments, and late arrivals are disruptive to our schedule and our other patients.

In order to maintain our schedule and respect our other patients' time, we request 48 business hours notification for cancellations or rescheduling of appointments. Cancellations and rescheduling of appointments must be made with Belmar Smiles' office personnel during business hours. Cancellations and rescheduling of appointments are **not accepted** by voice mail or e-mail. In the instance of a late cancellation (less than 24 business hours notice) or a failed appointment, there will be a $45.00 charge per hour of scheduled appointment time.

## Acknowledgement of Receipt of the Statement of Financial Policy, Agreement, and Cancellation Policy

I acknowledge that I have received a copy of the Statement of Financial Policy, Agreement, and Cancellation Policy for Belmar Smiles.

Christina Sehy VerSchave, DDS reserves the right to change the financial and cancellation policies that are described above. If the financial and cancellation policies change, I will be offered a copy of the revised policies at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Financial Policy, Agreement, and Cancellation Policy by requesting one be mailed to me.

**Name of Patient or Personal Representative:**_____

**Signature of Patient or Personal Representative:**_____

**Date:**_____