

FINANCIAL POLICY

In an effort to provide you with the highest quality care and still maintain lower prices for our services, we have established this financial policy to assist you in understanding and complying with our clinic's service fees. The patient or patient's guardian is responsible for payment of all services provided by the dental office of Jeffrey P Fish DDS. Please select a payment plan below:

- Plan A: Cash discount**
Receive a 10% discount if payment is received in full at the time of service, by cash or check

- Plan B: 50%, 25%, 25% in 60 days**
 - 50% on the day of service
 - 25% is due at 30 days
 - 25% of the balance is due at 60days

- Plan C: Thirds in 60 days**
 - 1/3 the fee on the day of service
 - 1/3 is due at 30 days
 - 1/3 balance is due at 60 days

- Plan D: Quarter payments in 90 days**
 - 25% the fee on the day of service
 - 25% is due at 30 days
 - 25% at 60 days
 - 25% balance + 1.5% interest due at 90 days

Insurance claims

Dental insurance policies are contracts between the insurance company and the insured. Insurance companies pay only a portion of your dental investment, that portion is specified by your insurance contract. It is **your responsibility to verify all insurance policies regarding co-pays, deductibles, and coverage**. All patient co-pays are due at the time of service. We are happy to accurately and efficiently submit all claims to your insurance company. However, in cases where your insurance company has not paid the services within 60 days, the patient or patient's guardian is responsible for the bill.

Services not covered by an insurance policy are the responsibility of the patient or patient's guardian. Even if you have insurance, we encourage you to select a payment plan from above for any services not covered by your insurance policy.

We reserve the right to run a credit check on any new patient. An outstanding balance of 90 days with no contact from you will be referred to our collection agency and you will be dismissed from our practice. Should you file bankruptcy, you will also be dismissed. A fee of \$25.00 will be assessed on all returned checks.

I have read and understand the financial policies described above. By choosing to proceed with my care, I am also agreeing to comply with these policies.

Estimate of fee \$ _____ Payment of \$ _____ Payment to begin on _____

Patient or guardian signature Date Jeff P Fish DDS staff signature Date

Any remaining account balances after 60 days will accrue a 1.5% interest charge.