QUAD CITY ENDODONTICS

FINANCIAL POLICY & HIPPA

To avoid possible misunderstandings regarding payments for services rendered, we are providing you with this statement of our financial policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our office staff.

1) For your convenience, our office accepts cash, personal checks and most major credit cards for services.

2) Please understand that we file and accept assignment of your insurance benefits as a courtesy to you. Most dental insurance plans do not cover 100% of the cost of your treatment. Because of this, you will be asked to make a down payment the day services are rendered. We will estimate as closely as possible your coverage, but until we actually receive payment from your carrier, it is just that – an *estimate*.

3) If your insurance denies coverage or does not pay *for any reason*, you are ultimately responsible for any and all charges incurred in our office.

4) If we do not receive payment from your carrier within 60 days, the entire balance is due from you.

5) In the event that you do not have dental insurance, we ask that *payment be made in full at the time services are rendered*

6) Balances older than 90 days will be subject to collection proceedings. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees

7) Returned checks will be subject to additional collection fees assessed by the bank

Thank you for trusting our office with your dental care. Any questions may be directed to Amy at (563) 359-4270 during regular business hours.

ACKNOWLEDGEMENT OF NOTICE OF FINANCIAL POLICY

My signature certifies that I have read and understand the above financial policy. I agree to abide by it, and will pay today for services rendered.

_____ _____

Signature (patient / guardian) Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

My signature certifies that I have reviewed a copy of this office's Notice of Privacy Practices.

_____ _____

Signature (patient / guardian) Date