FINANCIAL POLICY

It is the policy of Stonebridge Dental that all fees including co-pay, deductibles and non-covered services are due and payable on the date of service unless other payment arrangements have been made. There will be a $25.00 fee for returned checks.

Insurance coverage is considered by Stonebridge Dental as an agreement between the patient, the insurance company and the employer, where applicable. Stonebridge Dental is not a party to that agreement and as a result is not bound by any of the covenants, limitations, or restrictions of that policy.

As a service to our patients, we will file insurance claims for dental-related charges. Itemized bills will be provided to you for office services upon request. The filing of insurance does NOT release the patient from responsibility for charges for services which have been provided.

Charges for services not covered by insurance are due when a patient statement is received unless specific arrangements have been made for an extension of time. If you have special needs, contact our office. You are responsible for payment of services not paid in whole or in part by your insurance.

Statements showing the status of your account are mailed monthly. Please retain all your statements as itemized transactions are not repeated.

Stonebridge Dental is prepared to counsel any patient experiencing difficulty in meeting payment obligations. If you are unable to make payment when due, please contact our office as soon as you receive our statement. Special arrangements can be made in which the patient agrees to pay at regular intervals an amount based on his or her financial resources.

Accounts which are not paid within a reasonable period of time, and for which no special arrangements have been made, will be subject to placement with collection agencies following due notice.

Broken Appointments: This time has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change you appointment, we require at least 24 hours notice to avoid a $40.00 cancellation fee (emergencies are an exception).

I also authorize my insurance claim to be paid directly to Stephen R. Cash, D.D.S

Having read and understood the above statement, I agree to the terms set forth.

Signature_____Date_____