Lovell
FAMILY DENTISTRY

FINANCIAL POLICY AGREEMENT

Thank you for choosing our office as your dental care provider. We are committed to providing the highest quality of care in a comforting and professional manner. In addition, we are also dedicated to making top-quality care as cost-effective as possible.

REGARDING INSURANCE

Payment in full is required on your first visit if benefits cannot be confirmed. As a courtesy, our office will submit insurance documents on your behalf at no charge. If deductibles have been met, your estimated co-payment will be due at time of service. We cannot bill your insurance company unless you give us your completed insurance information. If this is not available, you will be required to make full payment at time of service. We reserve the right not to accept assignment of benefits.

If we are a participating provider for your group policy, co-payments and deductibles are due prior to or at time of treatment.

We urge you to read your policy. We will do our utmost to see that you receive the maximum benefits within the structure of your dental plan. However, our services are rendered to you, not the insurance company. Therefore, you are directly responsible to us for the obligation of payment for treatment.

Please be aware that your particular program may base its allowances on a fee schedule, which may or may not coincide with our fees. The amount your insurance carrier allows is determined by the plan chosen by you or your employer. This office does not determine the benefits to be derived under your policy. If you have any questions in regard to dollar disbursements of what your plan will cover, you must refer these questions to your employer or insurance company. Our practice is committed to providing the best treatment for our patients and we charge what is reasonable and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some of the services we determine to be necessary and prudent may not be covered under your particular policy.

It is our policy to wait a maximum of sixty days for all insurance payments. If the insurance payment has not been received by this time, we will require you to pay your balance. You will be reimbursed any payments subsequently received from your insurance.

MISSED APPOINTMENTS

For all non-emergency related missed appointments, a charge of $69.00 will be applied to your account unless we receive 24 hours advance notice. Please help us serve you better by keeping scheduled appointments.

WE ACCEPT CASH, CHECKS, VISA, MASTER CARD, AMERICAN EXPRESS AND DISCOVER
WE OFFER EXTENDED PAYMENT PLANS THROUGH CARECREDIT

I understand and agree that I am personally responsible for my account for services rendered, including any services covered by insurance. I have received and read a copy of the Office's Financial Policy. I understand and agreed to the financial policy. Further, I agree that if my account is not paid in full when due, I will pay the balance due plus cost of collections, including attorney's fees and court costs.

Signature:_____Date:_____

(Patient must sign above prior to any treatment)

Thank you for allowing us to provide your dental care.
Eric B. Lovell, DDS & Mary "Mim" Lovell, DDS