Rugby Dental Office

Financial Arrangement Form

We at Rugby Dental Office are committed to providing you with the best possible dental care and are pleased to discuss any and all of our professional fees at any time. Your clear understanding of our Financial Arrangement Form is very important to our professional dental relationship. If you have any questions or concerns, please ask one of our qualified team members.

Payment Options with No Insurance Benefits

Payment in full is due at each appointment. We accept Cash, Personal Checks, Visa, MasterCard, and Discover. Financial arrangements must be determined before any treatment begins and will only be extended to patient(s) having major comprehensive dental treatment. Fees and timeframe will be discussed prior to beginning treatment when you meet with the Dentist and treatment coordinator.

A service charge of 1.5% per month or 18% per year is applied to all balances that exceed 90 days.

Payment Options with Insurance Benefits

We will bill to any insurance company, however, it is **extremely** important that you are familiar with your benefit plan prior to having services rendered. It is important to check your dental benefit plan on a yearly basis as those benefits may have changed from a previous year. We do our best to **estimate** what your insurance company may pay; however, it is ultimately your responsibility and not that of Rugby Dental Office Dentists to know your plan. Keep in mind; this is an *estimation of benefits and* ***not*** *a guarantee of payment.*

Your estimated portion is due at the time of service. **Payment in full is due within 30 days once your insurance company has paid their portion.**

"I have read and understand the above stated financial policies."

Patient/Guardian Signature: ______________________________ Date: _______

Patients with insurance please read and sign the following as required by your dental insurance company:

"I authorize release of any information relating to this claim. I understand that I am financially responsible for all charges whether or not paid by insurance."

Patient/Guardian Signature: ______________________________ Date: _______

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