Sarver Family Dental
Jerome Sarver, D.D.S.
6035 Sterling Creek Road • Portage IN 46368 • 219-850-1218

SARVER FAMILY DENTAL FINANCIAL POLICY (page 1)
PLEASE READ CAREFULLY

Patient Name: _____ Date: _____/_____/_____

Sarver Family Dental is dedicated to providing our patients with the best possible care, and we strive to keep you as informed as possible at all times. We are always happy to discuss our professional fees, Financial Policy, or your responsibility with you at any time. Your clear understanding of our Financial Policy is important to our relationship with you.

- ALL PATIENTS MUST FILL OUT "NEW PATIENT FORMS" BEFORE THEY CAN SEE THE DENTAL PROFESSIONAL
- FULL PAYMENT IS DUE AT TIME OF SERVICE
- WE ACCEPT CASH, CHECKS, VISA, MASTER CARD, AMERICAN EXPRESS, DISCOVER, AND CARE CREDIT
- SARVER FAMILY DENTAL PROVIDES INSURANCE BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.

ADULT PATIENTS:

- All adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT:

- The adult accompanying a minor, his/her parent or guardian, is responsible for full payment at the time of service.

UNACCOMPANIED MINORS:

- Parents or Guardians of minors are responsible for full payment at the time of service. Any minor who comes into Sarver Family Dental without a parent or guardian will be denied service for non-emergency treatment unless a pre-authorized payment plan has been set up prior to the appointment.

INSURANCE:

- HEALTH INSURANCE: Sarver Family Dental provides insurance company billing as a courtesy to our patients for services rendered. In order to do this the patient must provide Sarver Family Dental with accurate health insurance information. We will process a primary and secondary insurance, but not a third party insurance. Prior to treatment Sarver Family Dental may provide you with an estimate for the costs of services. This is amount due at the time of service. The amount may be subject to adjustment by the insurance company when the dental service(s) claim(s) are submitted. In addition, some insurance companies have annual limits for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limits in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by Sarver Family Dental staff regarding his/her remaining benefits in any such benefit period.

- ESTIMATES: All treatment plans presented by Sarver Family Dental are an estimation for the costs of services to be provided to the patient based off the insurance information provided. This is an estimate only and your insurance company may not pay the full estimated amount. Any remaining balance after insurance company adjustments are the responsibility of the patient.

- RECEIVING CHECKS FROM THE INSURANCE COMPANY: The claims submitted by Sarver Family Dental on your behalf indicate that those benefits are assigned to Sarver Family Dental. In the event that a patients insurance company issues a check directly for services rendered by Sarver Family Dental, the patient is responsible for endorsing the check to Sarver Family Dental, or paying the total balance, withing ten (10) days from receipt. Failure to do so will result in the account being assessed additional fees.
See Delinquent Accounts

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SARVER FAMILY DENTAL FINANCIAL POLICY (page 2)
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MISSED APPOINTMENTS:

- If a patient cancels an appointment without providing at least 24 hours advance notice or fails to appear for an appointment without notifying the office more than 24 hours in advance, Sarver Family Dental reserves the right to charge a missed appointment or cancellation fee of $25.

RETURNED CHECKS:

- It is our policy that any payments returned due to non-sufficient funds for services provided by Sarver Family Dental will be subject to a $35 NSF fee. This amount is the patients responsibility and will be added to the patients account and will not be billed to the insurance company.

DELINQUENT PAYMENTS:

- INTEREST: In the event an account is not paid in full within thirty (30) days from issuance of a statement by Sarver Family Dental, or within ten (10) days from receipt of a check from my insurance carrier for services rendered by Sarver Family Dental, the outstanding balance will accrue interest at the rate of 1.5% per month (18% per year) until the balance is paid in full.

- COLLECTION FEES: In the event an account remains unpaid for sixty (60) days or more, Sarver Family Dental may refer your account to an attorney for collections. Should this happen the you will be responsible for, in addition to interest as outlined above, all costs and expenses associated with collecting your delinquent account, including, but not limited to, attorney fees and court costs.

By signing below, Responsible Party acknowledges that he/she has read and understands the terms of this Release and Financial Policy and agrees to the same as outlined above.

Printed Name: _____

Signature of Responsible Party: _____ Date: _____/_____/_____

Patients Name: _____

Relationship to Patient: _____