Financial Policy

Please read carefully and sign to acknowledge understanding and agreement.

Thank you for choosing **Ramsay Family Dentistry** as your dental care provider. We are committed to providing you with the best dental care available.

Regarding Insurance

- Since your insurance company may not cover all costs, we ask that you pay any percentage of your balance not paid by your insurance on the day of treatment, including impressions and/or preparations.
- For services that are not covered by your insurance, we ask that you pay the entire fee the day of your treatment; including impressions and/or preparations.
- We will attempt to answer any questions we can about your insurance whenever possible. Please understand that we cannot speak on their behalf. Your insurance contract is an agreement between you, your employer & your insurance carrier. In the event that your insurance company does not pay what was estimated you would be responsible to pay the remaining balance on your account.
- I hereby assign payment of dental benefits to the dental facility in the event the insurance check is otherwise issued to me.
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Patients without Insurance

- **For those patients without insurance coverage, the patient is responsible for payment on the day of treatment: including impressions and/or preparations.**
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No-Show Policy

- Our office requires 24 hours notice to cancel an appointment. We reserve the right to charge a fee of $50 for a no-show appointment.
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Returned Checks/Collections

- A service fee of $25 will be charged for checks returned for any reason.

- I agree to pay all reasonable costs you incur to collect this debt. This includes, unless prohibited by law, all reasonable attorney's fees, filing fees, court costs, collection agency costs, service fees, and other related collection costs or contingencies. I understand that if any unpaid balance is turned over to our collection agency that a fee ranging from 30%-50% will be added to the total balance due. I hereby give you or any of your agents or assignees to whom you turnover any unpaid balance permission to obtain a report from a credit reporting agency and to take reasonable steps to verify my credit and or employment information. I give you or any of your agents or assignees to whom you turnover any unpaid balance to contact me regarding this transaction or any future transaction at any telephone numbers of which they are aware including cellular telephones by manually dialing, using an auto-dialer or pre-recorded message.

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Signature of Patient/Responsible Party Date