One Woodfield Place Endodontics Financial Policy

PATIENTS WITH INSURANCE

If we are in-network with you insurance plan, we will ***estimate*** your portion as accurately as possible at the time of treatment. However, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. This estimate may be slightly more or less than the amount your insurance company will actually pay, in which case your will receive a refund or statement for the remaining amount due, respectively. Your deductible and/or copayment are expected in full at the time services are rendered.

If we are not in-network with your insurance plan, your claim will be submitted on your behalf, but payment is expected in full at the time services are rendered.

Please also keep in mind that if you have claims pending on your dental insurance plan, the amount of your benefits truly remaining versus what can be verified at the time you are at our office may be different. This may result in you having a larger balance remaining.

If for whatever reason, your insurance plan is not active, as designated by your insurance company, you will be expected to pay our usual and customary fees for the services rendered to you.

PATIENTS WITHOUT INSURANCE

Payment is due in full when services are rendered unless arrangement have been made ahead of time.

PAYMENTS

Payments can be made in cash, check, Visa, Mastercard, Discover or American Express. We also offer CareCredit to break your payments up over six months, while allowing you to paying our office in full. If you would like to learn more about CareCredit, please ask one of our receptionists.

If you have an outstanding balance with our office, you will receive a statement in addition to having our receptionists contact you. We expect that these balances to be paid within 30 days. If we have not received your payment by 90 days from the time services were rendered, your account will be hand over to a collections agency.

Patient name (please print): _____

Patient signature: _____ Date_____