



Office Payment Policies

Patient Responsibility for Payment

Final responsibility for all payment rests with the patient. All service fees are expected at the time of your appointment, as we do not accept monthly payment plans. Many insurance policies require co-payments and/or deductibles. You may pay with cash, check, VISA, or Mastercard. We will collect these at the time of registration, prior to seeing the Doctor or at point of discharge.

For **self-pay accounts** we accept cash, check, VISA, Mastercard, and offer third party financing plans that include some interest-free programs. To meet your financial needs, our business manager is available to discuss financial arrangements with you, by appointment.

Insurance Coverage

All services and procedures will be coded and billed to the highest level of specificity and with codes that most accurately describe services rendered. If a patient has dental insurance, we will make every attempt to conduct and bill commensurate with insurance benefits. Benefit information must be presented by the patient in a forthright and timely manner at your initial office visit.

The Insurance Company and You

Frequently, dental insurance companies may pay only part of the Doctor's fee and services. The extent of your benefits is determined by your individual policy. Please keep in mind that services have been rendered to **you**, the patient, not the insurance company, and you are ultimately responsible for any out-of-pocket expense.

Co-payment

Co-payments are expected at the time of service, before services are rendered. Failure to provide co-payment may result in denial of services until sufficient funds are presented to cover co-payment and/or other required fees.

I have read and comply with the office policies of AbCom Family Dental Care. I am aware that any treatment plan given to me is good for six months from today's date. I understand that the insurance portion is an estimate of the dental benefits provided by my insurance company. This estimate may also vary based on my remaining annual benefits.

Patient or Responsible Party

Date