Charles E. McElfish, DDS
Family & Cosmetic Dentistry

Financial Policy

As validated by my signature on the bottom of this form, I understand and agree that:
All patient balances are due immediately after treatment is rendered.

I understand I have the choice of several payment options:

Cash, check, money-order and all major credit cards.
Also there is a 5% discount for cash payment for those patients without dental insurance.

I agree the office reserves the right to charge a fee of $50 for any failed appointment or any appointments canceled with less than 24 hours advance notice.

Should a balance accrue on the account a statement will be sent and payment is to be made, in full, by the date on the statement. If payment is not paid within 90 days billing charges will drop each time a statement is sent . If insurances take an exceptionally long time to pay, you may receive a statement to alert you of the situation.

A returned check fee may also be applied and must be payable from you for each check payment returned to us by your bank.

I understand current Insurance cards must be presented at time of service
Dental insurance is a contract between the patient, their employer (if applicable) and the insurance provider. Submitting claims for payment to the insurance provider is a courtesy provided by the dentist, not an obligation. Ultimately, I am responsible for any treatment that is unpaid by the insurance provider.

If there is dental insurance on the account, I understand that the office has established the patient balance based on the information I have provided. Final treatment payment is subject to the terms and conditions of my insurance provider on the date of service. As such, until payment is received from my insurance provider, no patient payment is final.

Estimates and treatment plans are based upon information gained from the examination. As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. This is a preliminary estimate only and lab charges (if applicable) have been estimated and included total.

Estimates do not take into consideration any money that was billed toward my financial maximum or treatment limits that may have been used at other dental clinics.

A submission to my insurance provider will be sent to determine an approximate final investment. However, it is an estimate only. Final insurance splits may be adjusted upon receiving the predeterminations. Predeterminations from my insurance provider(s) are NOT a guarantee of payment.

As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. The office will make an effort to anticipate any changes in the treatment plan and advise me at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

The office will make every effort to accommodate my scheduling needs.

I have read, understand and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all fees for services rendered to me and/or my family.

First Name

Text

Last Name

Text

Patient or Legal Guardian Signature

Sign Here

Date

Aug 21 2024

Submit