

Drs. Amar Katranji, Kelly Misch, and Julius Bunek welcome you to our office!

Our Financial Policy

The following describes our office financial policy. Our office is committed to providing you with the best possible care. **Your understanding of our financial policy is an essential element of your care and service.** If you have any questions regarding any aspect of our policy, please feel free to present your question to our team members. **Payment for services is due at the time that services are rendered.** We accept cash, debit card, and for your convenience, Visa, MasterCard, Discover and third party financing through Care Credit and Lending Club. _____initials

Our patients who have dental insurance are expected to pay the amount of their *estimated* co-pay and deductible at the time of service.

Insurance Policy and Assignment of Benefits (For patients with DENTAL insurance only)

As a courtesy, we will file the forms necessary to see that you receive the full benefits of your coverage. Because your insurance policy is a contract between you, your employer, and the insurance company, it is your responsibility to make sure we have accurate and up to date insurance carrier information, restrictions of your policy, and billing information. If your insurance company has not paid your claim in full within 60 days the remaining balance will automatically become patient responsibility. _____initials

Please be aware some and possibly all of the services provided may not be covered by your insurance provider. Services which are not covered, downgraded, or fall under L.E.A.T. (least expensive alternate treatment) by your insurance, are your responsibility. Any **balance left unpaid after 30 days** will be subject to a 4% finance charge. After 60 days the account may be considered for collection and the account will accrue a collection fee in addition to any past due balances. _____initials

Scheduling Policy

The time reserved with your doctor/hygienist is scheduled according to your specific needs, and is extremely important. If you are unable to make your reserved appointment time, please contact the office no later than 72 hours PRIOR to your scheduled appointment. We do understand that life happens, but any missed appointments without the 72 hour notice may be subject to a \$50.00-\$100.00 charge. Habitual missed appointments (2 within 6 months) may be grounds for dismissal from the practice. Please note, arriving 10 minutes late to a scheduled appointment may require your appointment to be rescheduled for a later date, and a charge may apply. We neither recognize nor enforce the terms of divorce or child support decrees. All minor patients must be accompanied by an adult (parent or legal guardian). The adult accompanying the minor is required to pay in accordance with our policies. _____initials

A deposit of \$100.00 is REQUIRED to schedule all surgical appointments. This will be applied to your treatment scheduled. Please allow 5 business days for rescheduling of this appointment with no charge. If less than 5 days is provided for rescheduling, the deposit may be considered for partial or non-credit reimbursement. _____initials

I have read and understand the Financial Policy and Scheduling Policy for Jackson Implants & Periodontics, PLC. I agree to abide by these policies. By signing this, I also authorize my primary and/ or secondary insurance company to make payments according to Jackson Implants & Periodontics, PLC as directed.

Signature of Patient/Responsible Party

Date

Print Name