

OUR FINANCIAL POLICY- ROBERT L. BECKELMAN, D.M.D.

Patient Name: _____

Date: _____

Thank you for choosing our office for your dental needs. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are always available to answer your questions and/or assist you in any way we can.

Fees less than \$1,000 are due and payable at the time treatment is rendered. We accept cash, personal checks, or credit cards (MC, Visa, American Express, and Discover).

For our patients with dental insurance: We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. The insurance relationship constitutes an agreement between the insurance company and the patient. As such, we can make no guarantee of estimated coverage or payment. However, please know that we will do everything possible to see that you receive the full benefits of your policy.

Payment Options
(For treatment \$1000 and over)

Total Treatment Estimate: _____ Insurance Estimate: _____ Portion Payment: _____

1. Prepayment Courtesy.*

We are happy to offer a 5% courtesy for all treatment over \$1,000 that is paid in full prior to treatment commencing.

\$ _____ \$ _____ _____
Discount Adjusted Total Must be paid by

2. Payment as Services are Rendered:

If you wish to pay the estimated amount for treatment at the time services are rendered, we gladly accept cash, personal checks, and most major credit cards. Because we cannot guarantee your exact insurance coverage, there may be a balance remaining after insurance payment is received. Whenever choosing this option, we ask that you leave a credit card on file for any balance that may be owed.

3. Monthly Payment Plans:

"Same as Cash" Interest-Free Credit Line \$ _____
Monthly Payments (up to 12 months) interest free, with credit approval Monthly Total

Extended Payment Plan
For treatment plans between \$1,500 & \$25,000 Range: \$ _____ to \$ _____
18-60 months duration, no down payment required, payments as low as \$59 a month, no pre-payment penalty, with credit approval

3 Equal Monthly Payments \$ _____ \$ _____
33% initial down payment by cash, check or credit card Down payment 2 Monthly Payments
followed by two monthly installments.

"Lay-Away" Plan
Treatment commences after comfortable monthly payments are made which equal the estimated patient portion.

* Does not apply to senior citizens who already have a discounted fee.

I, _____, understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office. Any insurance claim not paid in full after 60 days will become my responsibility to pay at that time.

FINANCIAL RESPONSIBILITY

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSEMENT FOR THE PAYMENT OF FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES AND OTHERS PAY A PERCENTAGE OF THE CHARGE. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AND CO-INSURANCE AMOUNTS OR ANY OTHER BALANCES NOT PAID FOR BY YOUR INSURANCE CARRIER.

IN ORDER TO CONTROL OUR BILLING COSTS, WE REQUEST THAT OUR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT. ANY ACCOUNTS DELINQUENT OVER 90 DAYS WILL BE SUBJECT TO SERVICE CHARGES OF 1.5% PER MONTH. IF THIS AMOUNT IS ASSIGNED TO AN ATTORNEY FOR COLLECTIONS AND/OR SUIT, THE PATIENT AND OR GUARANTOR WILL BE RESPONSIBLE FOR REASONABLE ATTORNEY FEES: COSTS OF COLLECTIONS, COURT COSTS AND INTEREST FROM DATE OF SERVICE.

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO DETERMINE ELIGIBILITY FOR PAYMENT AND TO OBTAIN REIMBURSEMENT OF MY CLAIM. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE TO WHICH I AM ENTITLED INCLUDING DENTAL INSURANCE TO:

ROBERT L. BECKELMAN, D.M.D.

THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY THIS OFFICE IN WRITING; A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE THE RELEASE OF ALL INFORMATION NECESSARY TO SECURE PAYMENT.

SIGNED _____ DATE _____

ROBERT L. BECKELMAN, D.M.D.
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