ROBERT S. CARLISH, D.M.D. **PRACTICE LIMITED TO PERIODONTICS**

140 Piney Forest Road, Danville, Virginia 24540 **Phone 434 793-1400 Fax 434 793-1401**

FINANCIAL POLICY

Thank you for selecting us to be your periodontal care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. To help provide these services, it is necessary for us to have a Financial Policy stating requirements for payment of services for you to read and sign prior to treatment. All patients are required to complete our health history form and provide appropriate insurance information before seeing the doctor.

Full payment is due at the time of the initial appointment, unless informed otherwise by our office. We accept cash, checks and credit cards including Mastercard, Visa, Discover, American Express and Care Credit. We will file your insurance carrier(s) for this appointment and apply any payment from them as a credit towards your treatment or we will refund you this credit, at your request.

DENTAL INSURANCE – As a courtesy, our office will file claims with your dental insurance carrier(s) for services we provide. The part of the charge not paid by your insurance (co-payment and deductible) is your responsibility and is due at the time of service. Any insurance you have is a contract between you and your insurance company and we ask that you assist us in contacting them in the event that services are not paid within 30 days. We ask you to notify us if your insurance coverage has changed. Claims unpaid after 60 days are the responsibility of the patient. Some, and occasionally all, the services we provide may not be covered by your insurance plan and fees for these services may not be considered within the *usual, customary and reasonable* (UCR) fees established by your particular insurance plan. Accordingly, the patient is responsible for any balance above your policy's UCR except in those cases where our office is a participating provider with that dental insurance plan.

SELF-PAY – If you do not have dental insurance, we ask that you pay the entire balance for treatment provided at the time of service unless other arrangements have been made with our office. We offer discounts for services rendered when the total recommended treatment is paid in full prior to or when treatment is begun. We also offer a direct deposit option that allows us to deduct your credit card or bank account a specified amount each month towards an unpaid balance.

Financial arrangements and regular payments must be made for balances carried on account by our office. Allowing an account to become seriously past due will result in being turned over to a credit bureau, collection agency and/or the court system. The responsible party will also be required to pay all fees associated with this type of action.

I acknowledge that payment is due at the time of treatment, unless prior arrangements have been made with our office before the appointment. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. If I am the insured, I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby authorize and direct assignment of dental benefits directly to Dr. Carlish for services rendered.

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Signature of Patient or Responsible Party Printed Name of Patient or Responsible Party Date