DREW BEATY DDS
family and cosmetic dentistry

Financial Policy And Agreement

Outstanding Patient Service is Our Goal

The goal of Dr. Beaty and team is to make sure that you receive the highest quality dental care and service. One step is to make certain that our financial policies are clear and understood by you.

Insurance – We go the Extra Mile

If you have insurance, we will make a good faith estimate of your benefits and defer billing you for that amount for up to 60 days. We will take complete care of completing and filing the appropriate claim forms with your insurance company. We will also track your claim and make sure that it is paid in a timely manner. We will follow up with your insurer when claims are not processed efficiently and attempt to expedite payment. We are also happy to provide your insurance company x-rays or other information they may require.

If your insurer denies coverage, or if we otherwise do not receive payment within 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurer and/or your employer and your insurer. **Although we will make every effort to help you obtain your benefits, we cannot force your insurer to pay.**

Your Payment is Due at the Time of Treatment

Fees for treatment are due at the time of treatment after deduction of your good faith estimate of insurance benefits as described above.

Payment Options:

Cash Check Visa MasterCard Care Credit (Third Party Financing with a short application)

Patient Responsibility

I acknowledge my responsibility for payment of the services received from Dr. Beaty in accordance with Dr. Beaty's regular fees and terms. I understand my responsibility is not modified by whether any third party (insurance) pays for all, part of none of the charges.

I understand that this account becomes delinquent if not paid within 60 days after billing and that at that time a Finance Charge of 1.5% of the unpaid balance will be charged every month until balance is paid in full.

Assignment and Release

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all services not covered by my insurance and I authorize release of any medical care information requested by my insurance carrier.

Patient Signature: _____ Date: _____

Staff Member's Initials: _____ Date: _____