ORTHODONTICS

Dr. Hoda Salim DDS, MS

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Financial Policy

We are dedicated to providing the best possible care and service to you and your family. Your complete understanding of your financial responsibilities is an essential element of your care and treatment.

Certain fees in need of payment at the time of service. These are records fees, x-rays, impressions, appliance fees, retainers and specific charges designated and assigned by the doctor. Patients in treatment have a contract and fees to be paid as specified in the contract. If this account becomes delinquent, (30 days past due), the responsible party may be charged a $25.oo monthly late fee. If necessary, upon written notice of delinquency, the undersigned agrees to assume all costs and expenses including reasonable attorney fees and / or collection fees to affect collection of this account.

Patients with orthodontic insurance plans are asked to pay their co-insurance, deductibles or any non-covered services at the time of their visit. **As a courtesy,** we will file your insurance claim for you. If the insurance does not pay in a reasonable length of time, we will have to look to you for payment. Patients are expected to know the benefits provided by their insurance company. Please contact your insurance company to review your benefits. **Insurance verification is not a guarantee of payment.** You are responsible for all charges regardless of insurance coverage. You agree to pay your account with this office in accordance with payment terms of this office.

You are expected to notify our office if your insurance coverage changes. Our office will periodically ask you to update your records. You will be expected to provide full and complete information to our office in order to bill the correct insurance company. If insurance pays directly to the insured, it is the insured responsibility to inform our office of non-payment within 60 days of the service provided.

We are an orthodontic office and do not file medical insurance claims. Dental insurance claims can be filed for contracted services and records upon request.
I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of responsible party **Date**

Printed name of patient **Date**