RICK A. JONES FAMILY DENTISTRY
2300 YORK RD, STE 210, TIMONIUM, MD 21093
410.560.6855

FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All patients complete out information and insurance form before seeing the doctor.

PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/DISCOVER.

REGARDING INSURANCE:
We may accept assignment of insurance benefits with your first visit. However, we do require your deductible and copayments to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and that company. We are not a party of that contract. In the event we do accept assignment of benefits we suggest that you be preapproved on our extended payment of fill out our credit card authorization to bill that account in full within 90 days. This allows the balance to be automatically transferred to your credit card. Please be aware that some, and perhaps all of the services provided may be non-covered and not considered reasonable and necessary under your insurance.

Usual and Customary Rates:
Out practice is committed to providing the best treatment for our patients and we charge what is usual and customary of our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment Plan Options: Short (30-60 day) payment plan may be made at the front desk.

Adults: adult patients are responsible for full payment at time of service.
Minors: The adult accompanying a minor & the parents/guardian are responsible for full payment.

Missed Appointments: Unless canceled at least **24 hours** in advance, our policy is to charge $80.00 for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Any account balance that is given to an outside collection agency will be subject to agency costs.

Thank you for understanding out Financial Policy. Please let us know if you have any questions or concerns.

I have read and agree to this Financial Policy.

X____ **Date:** ________________________
Signature of Patient/Responsible Party