



At Dr. Posey's office we share the concern of our patients about the increasing cost of dental and medical care. Our fees are comparable to the usual and customary charges made by other general dentists in this area. These charges are based on doctor's costs, time, and skill involved. You will be given a written estimate of the charges before treatment is started.

Accounts with a returned check will be charged a \$30.00 returned check fee. Accounts with balances over 60 days will be considered overdue and subject to interest charges that are generated by our system at 21%.

#### FOR PATIENTS WITHOUT INSURANCE

Patients without insurance are requested to pay their charges at the time of service. Senior citizens 65 and older are given a 10% discount.

#### FOR PATIENTS WITH INSURANCE

The office of Dr. Posey contacts insurance companies as a courtesy to our patients. Patients with insurance coverage are asked to pay their estimated portion at time service is provided. Please remember that insurance estimates are based on verbal, computer responses, or faxed information provided by your insurance company and are not a guarantee of payment. The amount of insurance coverage is an estimate only and may not reflect what your insurance carrier will actually pay. Final determination will be made by the insurance company once the claim has been processed.

We will gladly discuss your treatment with you and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Not every service is a covered benefit with all insurance contracts. Some insurance companies are selective in what services are covered. Our concern is your wellbeing, not what the insurance will cover.
3. Services cannot be provided on the assumption that the charges will be paid by the insurance company: therefore the patient is responsible for the bill, regardless of the insurance coverage. We do not let insurance dictate what is best for you.

\*\*\*Due to an increase number of patients not meeting their financial obligations to this office, effective June 1, 2006 a credit card number will need to be left with us for any balance due after your insurance has paid. If needed, you will be notified via phone message regarding the amount and date that charges will be applied to your credit card. Your credit card number will be destroyed after the balance is paid in full. If you are not comfortable leaving your credit card number

with us, you may pay in full at time of service. For your convenience, cash, check, VISA, MasterCard, Discover, and Care Credit are accepted.

If a payment from your insurance company results in a credit on your account, we will gladly send that to you as soon as possible.

I hereby assign to Dr. Posey the insurance benefits which are otherwise payable to me for his charges and direct that insurance payments be made directly to him. This assignment will remain in effect until revoked by me 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 assignee to release all information necessary to secure the payment. This is binding in court if needed to proceed.

PLEASE INITIAL ONE OF THE FOLLOWING OPTIONS AND SIGN

\_\_\_\_\_ I authorize this office to charge any balance to my credit/debit card after insurance pays their fees.

\_\_\_\_\_ I authorize this office to charge any balance to my credit/debit card after insurance pays their fees, but would like to be informed by phone if the amount is over \$\_\_\_\_\_.

\_\_\_\_\_ I will pay my fee in full at the time of service, with cash, check, Visa, MasterCard. (You will be reimbursed from your insurance company or given a refund from this office if you have dental insurance if there is a credit due after final payment).

\_\_\_\_\_  
Signature of responsible party

\_\_\_\_\_  
Date

Your signature indicates that you have read and understand the above information provided to you and that you will be responsible for payment of fees the day of service.