AURORA
DENTAL GROUP

We Make You Smile.

STATEMENT OF FINANCIAL POLICY

Thank you for choosing us as your dental health care provider! We are committed to the success of your treatment and care. Please understand that payment of your bill is part of this treatment and care. The following is our Statement of Financial Policy, which we require all of our patients to read, understand, and sign prior to any treatment or care.

When is Payment Due
Payment is due at the time services are rendered in the office. If you have dental insurance the portion that is not expected to be paid by the insurance will be due at the time of service. ***We accept Cash, Checks, Visa, MasterCard, and Discover. For those who qualify, we also offer financing through CareCredit.***

About Your Insurance Coverage
Your policy is a contract between you and your insurance company. Since we are not a part to the contract, your account balance is your responsibility whether your insurance pays or not. As a courtesy, we will file a claim on your behalf. We will be happy to provide your insurance company with any additional information needed to expedite the payment of your claim. However, if your insurance does not pay within 60 days, you will be responsible to pay the balance of unpaid charges and follow up with your insurance directly.

Self-Pay or Self-Filing
Patients who do not have insurance coverage, who are unable to provide us with valid insurance information or who wish to file their own insurance claims are responsible to pay 100% of charges at the time services are rendered.

About our Staff
Our staff has been trained to understand many insurance company policies, but they **DO NOT** have all the answers about your specific benefits. Please contact your employer for a copy of your Benefits Guidebook, or call your customer service number located on the back of your insurance I.D. card to obtain detailed information about your plan coverage.

Past Due Account Balances
If your account balance becomes past due, appropriate action will be taken to collect the amount due. All balances over 60 days are subject to 5.0% interest. If you have issues that prevent you from paying the full balance due, please contact our office so we can help find a solution. If your account is in Collections, you may be dismissed from the practice and no longer eligible for services until your balance is paid in full.

Returned Checks
The fee for each check returned for insufficient funds is $25. This fee will be automatically charged to your account when your check is returned from the bank.

Cancellation Policy
Aurora Dental Group requires a minimum of 24 hours advanced notice to avoid a cancellation fee.

I HAVE READ THE STATEMENT OF FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THE POLICY.

Patient Name _____

Signature of Patient or Guardian _____ Date _____

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