Eric C. Solberg, D.D.S, P.C.

Financial Policy Form

Thank you for selecting us as your personal dental care team. To promote a long-term mutually satisfying relationship, we would like to explain our office policy regarding treatment, insurance, appointments and fees. **Please** read this carefully and ask any questions or bring up any concerns you may have **BEFORE** treatment is rendered. SUBMISSION TO TREATMENT IMPLIES CONSENT TO TERMS OF THIS AGREEMENT.

INSURANCE: If this office is able to accept your insurance company's assignment of benefits, the patient is still **fully responsible** for the charges for treatment rendered. Your insurance **may not cover** the services or may only **partially** cover them and any **estimate** give by this office is considered **a guideline** until the final insurance is received and the patient's account is reconciled. The office can make NO GUARANTEE of the actual payment by your insurance company. For services that have been predetermined, the amount the insurance company may pay may be subject to maximums, deductibles, limitations and non-payment due to employment status.

PAYMENT IS DUE AT THE TIME OF SERVICES: When insurance applies we may collect any deductible and estimated co-pay at this time.
If you are not covered by dental insurance, your balance for treatment is due the same day of service. We do not accept payment arrangements unless prior authorized by the doctor **before** any treatment is started.

PROSTHETICS: Crowns, dentures, bridges etc., **Failure by member to return for the delivery of this item is subject to doctor time and lab fee charges.**
____________Initals

MISSED APPOINTMENTS: We request that you give us at least a 24 hours notice when you realize that you cannot keep an appointment. **When the requested notice is not given, a $50.00 fee may be charged.**

Please note: Any account balance that is left unpaid after 90 days will be sent to a collection agency or attorney by our office. All accounts past due are subject to collection. All fees, including, but not limited to, collection fees, attorney's fees, and court fees, fees incurred to enforce payment required by this agreement, shall become your responsibility in addition to the balance due in this office.

RETURNED CHECKS: There is a $35.00 fee for returned checks. The check must be picked up personally and cash must be paid to cover the check and the return fee.

Your signature below will be used as authorization of insurance benefits to be paid to this office and indicates that you have read and understand the financial policy of our office as it relates to you.

Signature: ____ Date:_____________________
Patient / Responsible party / Parent or Legal Guardian if patient is a minor

Please print name: ____