Financial Policy

Thank you for choosing Fox Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of the optimal care as easy and manageable as possible. We will provide you with an estimate of the fees expected. When estimating insurance coverage, we must also stress the word **"estimate"** as dental benefits are determined by each patient's dental contract. Most dental insurance plans are designed to assist patients with their dental expenses; very few dental plans fully cover all dental services. As a courtesy to you, we will file your insurance forms. Insurance coverage, reimbursement, and benefits are contract between you and your insurance carrier.

Please read the following statements. If you have any questions regarding this information, please ask us, we are here to help you.

- The estimated patient portion & co-payments for services rendered are due at the time of service, unless prior arrangements have been made. For your convenience, financing may be obtained for full and/or partial treatment through Care Credit, a third-party financing company. Automatic payment option with debit/credit card.
- As a courtesy to you we will bill your insurance; however, this is **NOT** a guarantee of insurance payment. Payment of dental services not covered or paid by your insurance is required at the time services are provided.
- I understand that even if I have dual insurance coverage, there may be instances where the two insurances will not pay 100%. In such cases, I am responsible for any amount not paid by insurance(s).
- A 1.5% per month (12% annually) finance charge may be added to any account with a past due balance of 90 days starting from the date services are rendered.
- We do not accept OHP (Oregon Health Plan), Medicare or Medicaid.
- Nitrous oxide is available at **$120.00** Payment is due at the time of service. This is **not** a covered benefit on most insurance plans.

I have read and understand the above stated guidelines and services. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the doctor to release all information necessary to secure payment of benefits. I authorize and request my insurance company to pay directly to the dentist the insurance benefits otherwise payable to me. I authorize the use of my signature below on all insurance submissions. I understand that my dental insurance may pay less than the actual bill of services.

Responsible Party Signature_____ Date_____

Relationship to Patient_____

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