HARPETH
—ENDODONTICS—

Financial Policy

All patients with or without dental insurance will be required to pay for services and/or expected co-pays and deductibles at the time services are rendered. Our preferred methods of payment are cash or personal checks. For your convenience we also accept Master Card, Visa, Discover, American Express, CareCredit, Apple Pay and Google Pay. For patients without dental insurance, we offer a cash/personal check discount. Unfortunately we cannot extend this to patients filing with dental insurance, as your insurance company has set our fee schedule contractually.

For all patients with dental insurance, as a courtesy we file and process your insurance claim for reimbursement as long as we have complete insurance information. Please keep in mind your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. All fees and out of pocket expenses are set by your insurance company not Harpeth Endodontics. Our financial relationship is with you, not your insurance company. All charges are ultimately your responsibility whether your insurance pays on your account or not. Please be aware that not all services are covered benefits in dental contracts. If your insurance company does not pay toward your claim within 45 days of the date of service, denies payment of the claim, or in the event your insurance is canceled/terminated for any reason, you are responsible for the entire fee amount including the insurance portion. Please note that if you are given a financial estimate of your services prior to service being rendered that it is **ONLY AN ESTIMATE** of charges. It is possible that your dental insurance may pay less than or more than was estimated. If overpayment is made we will issue you a refund.

For all patients with or without dental insurance, balances remaining after 60 days will begin to accrue a finance charge of 1.5% from the date of service on the unpaid balance of 18% annum. Balances remaining after 90 days are subject to being turned over to collections if no earnest attempt has been made to make payment on the balance. Declined credit card transactions will incur a 2% fee that will be added to your total balance. Returned checks will incur a $50 fee that will be added to your total balance.

By signing below, you state that you have been notified and understand this policy.

Patient Name:_____ Date:_____/_____/_____

Patient Signature:_____