

Millhopper Family Dentistry
3510 NW 43rd Street
Gainesville, Florida 32606
www.millhopperfamilydentistry.com

Standard Financial Options and Standard Fees Agreement

- 1) We accept **Cash, Check, Visa, MasterCard, Discover, American Express** and **CareCredit** cards.
- 2) We have applications where payment arrangements can be made with Capital One or CareCredit
- 3) An appointment reservation deposit of 50% (regardless of insurance benefits) is required when scheduling an appointment for services totaling \$400.00 or more. This deposit is non-refundable (if the appointment is missed) at the discretion of Millhopper Family Dentistry, P.A.
- 4) We offer an 8% Bookkeeping Courtesy to those patients who have a treatment plan exceeding \$2000.00. This courtesy is extended to payment in full of all services planned regardless of insurance benefits when payment by cash or check is received prior to the initial visit of the proposed treatment plan. If you choose to pay by credit card, we can give you a bookkeeping courtesy of 5%. **It is not offered on CareCredit or Capital One plans.**
- 5) Dental Insurance: We will be happy to submit an insurance claim for you as a courtesy. You **must complete and sign a claim form** to be kept on file for assignment of benefits. We need one for each family member. It is your responsibility to inform us of any changes in your insurance carrier or policy. We will submit a pre-treatment for major services to determine your insurance benefits upon request. If your insurance company denies your claim, we expect payment of the full balance within 10 days of the notice you receive from your insurance company. Professional services are rendered to a person, not to the insurance company. **Our treatment is based on the dental need of the patient, not the insurance company benefits. We cannot render services to a patient on the assumption that the charges will be paid by the insurance company, nor can we know every service not covered by your insurance company.** We will help in any way possible to file your claim or handle any insurance queries you may have. It is your responsibility to be involved with your insurance company. **The patient is responsible to the doctor and the insurance company is responsible to the patient.**
- 7) I agree to accept the standard fees of this office regardless of my insurance benefit agreement and I understand that there may be a difference in the insurance plan fee and the standard fee. I take responsibility for the entire fee charged. I understand that this office expects that I pay in full for the services as they are provided. If I do not hear from my insurance company within 60 days, I will contact them and inform Millhopper Family Dentistry of the situation.
- 6) Our billing system will post a **service charge** of 18% annually (1 1/2% monthly) on account balances of **60 days or more**.
- 7) Returned Checks: There is a \$35.00 handling fee for any returned check.
- 8) Missed Appointments: No Charge will be made for rescheduling an appointment provided a 48 hour notice has been given; otherwise a **minimum charge of \$25.00 per half hour** of the missed appointment will be posted on the account. Payment is expected within 10 days. Please remember that **this time has been reserved specifically for YOU!**
- 9) **Attorney and/or Collection Fees:** Any fee incurred in collection of a delinquent account will be charged to the patient's account.

We are here to help no question is too small for you to ask. Please feel free to call when you have a question.

Thank you for your loyalty and for your referrals of your friends and family.

I have read and understand this financial policy and realize my responsibility. _____ (initials)

I authorize release of any information and/or x-rays relating to my dental treatment to the insurance company, attorney or collection agency in collecting the full cost of the services provided for myself and my family. _____ (initials)

I authorize release of any information and/or x-rays to dental offices where I have been referred. _____ (initials)

I have received a copy of this office's Notice of Privacy Practices. _____ (initials)

NAME (Printed)

Signature

Date

If you are the legal representative of the patient(s), please print patient(s)' name(s) and describe your authority:
