#### Adams Dental Center

**Dr. Kent E. Dodson, D.D.S., P.C.**

#### 8251 Northwoods Drive, Lincoln NE 68505

Phone (402)484-6666 Fax (402) 484-6696

**Office Policy**

It is the goal of this office to provide you with the finest quality dental care possible. We believe that a clear definition of our financial and insurance policies will allow the patient, doctor, and staff to concentrate on the most important issue being, the treatment and maintenance all of your specific dental needs.

We will send a pre-treatment estimate to your insurance upon your request. If services are performed before the estimate is received back from insurance, we will estimate your portion that will be due the day of treatment.

Please understand that we can only estimate your insurance company’s payment. Any balance due after an insurance payment is received is your financial responsibility and a bill will be sent to you no later than 30 days after receiving insurance payment. Any payment received in excess of your balance will be credited to your account.

PLEASE NOTE & initial below

\_\_\_\_ A $30.00 charge will be assessed for any missed/no-show appointment.

\_\_\_\_ A $20.00 charge will be assessed for any cancelled appointments without 24-hours notice.

\_\_\_\_ Deductibles and estimated co-ins must be paid in full on the day of service.

\_\_\_\_ If you do not have insurance payment is required at the time of service in full.

­­­­\_\_\_\_ If your insurance company sends payment directly to you, payment in full is required on the day of service.

As a courtesy to you, we will file your primary and secondary dental insurance. We do not file to 3rd or 4th insurance carriers. By signing this office policy, you are assigning all insurance benefits to us.

Your dental insurance is a contract between you, your employer (if it is a group dental plan) and the insurance company. Not all dental services are covered benefits in all dental (or medical) insurance contracts. The filing of insurance claims is a courtesy that we extend to our patients; however, all charges are your responsibility from the day services are rendered regardless of insurance coverage.

We accept cash, check, money order, **Care Credit**, and all major credit cards. Any balance over 30 days old will be assessed a finance charge of 18% A.P.R. (1.5% per month). If the account is 90 days past due you will be sent to collections and will be dismissed as a patient. We will forward your dental records to the dentist of your choice upon receipt of written permission to do so when your balance is paid.

Please indicate the manner in which you prefer to handle your account with Adams Dental Center:

* I have dental insurance, I will pay my estimated portion on the day of treatment.

❑ I do not have dental insurance, I will pay in full at the time of service and receive a 5%-7.5% discount.

* I wish to apply for a Care Credit Account (12 months interest free financing).

I have read, understand and agree to the office policy above.

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Signature of patient OR parent/guardian if patient is under 18 Date