Betty Jo Schope
3464 Briargate Blvd.
Colorado Springs, CO 80920
(719) 260-8089
www.schopedental.com

Financial Policy

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality of dental care utilizing only the best materials and education available. In our process of doing so, we have formulated a financial policy to continue to provide excellent service to you and minimize our administrative costs.

For those patients with dental insurance, as a courtesy, we will assist you in processing your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the *Assignment Of Benefits Agreement* below Your co-payment amount is due when services are provided unless you have a written financial arrangement on file.

Payment is due at the time service is provided, unless previous arrangements have been made. Our office accepts cash, personal checks, MasterCard, Visa, Amex and Discover. Monthly & outside financing options are available. Please ask for details.

All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, and not with your insurance company. Your insurance plan is a contract between you, your employer, and the insurance company. Our office is not a party to that contract or any possible restrictions.

Returned checks and balances older than sixty days may be subject to collection fees and finance charges at the rate of 1.50% monthly. Additionally, charges may be incurred for broken appointments and appointments cancelled without forty-eight business hours advance notice. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

If you have any questions regarding our financial policy, please do not hesitate to ask. We are committed to providing you with the most positive experience in dental care.

_____ _____

Patient Signature **Date**

Assignment of Benefits Agreement

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the processing of that claim. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this form and any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- We require you to pay the co-payments, which is the estimated amount not covered by your insurance company, at the time we provide service to you, unless you have made a written financial arrangement.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 90 days, we will close the claim and bill you for the balance due at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and request of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE CONDITIONS. I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY MY, OR ANYONE COVERED UNDER MY INSURANCE POLICY, DENTAL BENEFITS DIRECTLY TO DR. BETTY JO SCHOPE.

_____ _____

Signature of Patient / Responsible Party **Date**