

FINANCIAL POLICY

The following is a brief detailed description of our financial policy:

- We reserve the right to collect payment before services are rendered.
- We accept cash, check, Visa, MasterCard, Discover and American Express.
- We will be happy to assist you with applying for financing, should you desire. The company we work with is:
 - Lending Club
- **Please remember that you are fully responsible for all fees charged by our office regardless of your insurance coverage.**
 - Not all services are a covered benefit. Benefits may vary on different insurance plans. It is your responsibility to verify your insurance coverage.
- Fees for non-covered services, deductibles, and co-payments are due at the time of treatment.
 - Because insurance policies vary greatly, we can only estimate your coverage and cannot guarantee coverage due to the complexities of insurance contracts.
 - Your estimated portion must be paid at the time of service.
 - We will bill your insurance companies for services rendered and allow them 45 days to remit payment.
 - If your insurance company does not pay your claim within 60 days, you are expected to pay the entire balance due.
 - All unpaid charges over 60 days in age accrue 5% per month finance charge
- Delinquent accounts are defined as remaining balances that do not comply with the agreement stated here. Also accounts that have incorrect or no forwarding address. The following fees are added to delinquent accounts:

1. A late charge of \$20.00 added to the outstanding balance after 60 days.
2. \$30.00 service charge for accounts sent to Credit Bureau (CB); and
3. All attorney, court, and miscellaneous collection costs.

- We understand that temporary financial problems may affect your ability to make timely payments on your account. We ask that you contact us if you encounter such problems, so that we may assist you in the management of your account.

We appreciate your trust and the opportunity to serve you. If you have any questions or need assistance regarding your account, please contact our office at (850) 934-2820.

I have carefully read and understand this Financial Policy, and agree to the conditions. I authorize and request my insurance company to pay directly to Thomas Ryan McPherson D.M.D. PLLC. I agree to be responsible for payment of all services rendered on behalf of my dependents.

Patient/Parent/Guardian – Printed Name

Date

Patient/Parent/Guardian – Signature

Date