JORDAN M. JOB, DDS
OFFICE FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we ask you to read and sign prior to treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS

WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL

OUR INSURANCE POLICY: If all insurance information provided is correct and kept updated by the patient, we will file your claim with your insurance company. However, your uncovered portion will be due at time of service. Your insurance policy is a contract between YOU and YOUR INSURANCE COMPANY-we are not a party to that contract. If your insurance company has not paid your bill within 30 days You are responsible to pay the balance.

Please be aware that all services provided may not be covered by your insurance plan and may not be considered reasonable and customary as determined by your insurance company. It is your responsibility to know your insurance plan and covered services. If we have problems collecting payment from your insurance company, you may be asked to pay your balance at the time of service and get reimbursed from your insurance company.

Our office DOES NOT handle filing of Secondary Insurance claims unless prior arrangements have been made and all information is given to us prior to processing Primary Insurance.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is considered usual and customary for our area. You are responsible for any unpaid balances that your insurance company does not consider reasonable and customary.

MINOR PATIENTS:

We request that all minors be accompanied by an adult at all times. The adult accompanying the minor or the parents (or guardian) will be responsible for full payment unless other arrangements have been made with our office prior to the appointment.

MISSED APPOINTMENTS:

Unless cancelled 24 hours in advance, our policy is to charge $35 for the missed appointment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I HAVE READ, UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

x_____Date:_____
RESPONSIBLE PARTY