

Financial Agreement



SOUTHERN MINNESOTA ENDODONTICS

Thank you for choosing Southern Minnesota Endodontics as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. Below details our Financial Policy and Patient Responsibilities, which we require you to read and sign prior to any treatment.

- All patients complete our information and insurance form before seeing the doctor.
- **FULL PAYMENT IS DUE AT THE TIME OF SERVICE.**
- For your convenience we accept cash, personal check, or credit card.
- We also offer a convenient payment plan through Care Credit.

PATIENTS WITH INSURANCE COVERAGE

We accept assignment of insurance benefits from most dental insurance companies. However, we do require your co-payment be paid at the time of service. The balance incurred is your personal responsibility whether your insurance company pays or not. Coverage amounts vary from policy to policy and this office cannot guarantee the amounts of coverage offered by your insurance carrier. It is your responsibility to seek coverage amounts and limits of liability on your insurance policy. We cannot bill your insurance company until you give us your insurance information. You understand that your policy is a contract between you and your insurance company, this office holds no party to that contract and likewise will not be held responsible in the event your insurance company denies any claims. Any excess monies we collect will be refunded to you the day we receive the insurance check. In the case of underpayment by your insurance company, the remaining balance will be due within 30 days.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for specialists in our area. Each dental insurance company has its own formula for determining how much it will reimburse. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

DELINQUENCY

In the event your account is referred to an outside collection agency or an attorney, you will be responsible for the collection costs and/or reasonable attorney fees.

I have read and understand Southern Minnesota Endodontics' Credit Policy and Patient Responsibilities with respect to payment on my account.

X _____ Date: _____
Signature of Patient or Responsible Party