EZ DENTAL ASSOCIATES – OUR FINANCIAL POLICY

Thank you for choosing us as your dental 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 require you read, and sign prior to any treatment.

All patients must complete our information form in its entirety before seeing the doctor.

WE ACCEPT CASH, CHECKS, OR ATM/CREDIT CARDS.

REGARDING YOUR INSURANCE

Your Insurance policy is a contract between you and your insurance company. We are not a party to that contract. You are responsible to know your insurance policy. If your insurance company has not paid your account in 60 days, the balance will automatically be transferred to your responsibility. Please be aware that some and perhaps all of the service that are provided may be uncovered services, and not considered reasonable and necessary under the program if the doctor is non-participating with the insurance company. Should payments be sent directly to me, it is my responsibility to forward payment directly to physician. This office does not accept any and all Medicaid insurances. By signing this waiver, you are aware that you are responsible.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS

Adult patients are responsible for full payment according to their plan at the time of service, or if other payment arrangements have been made.

MINOR PATIENTS

A parent or guardian must accompany a minor. The adult accompanying the minor is responsible for full payment. **Unfortunately, we cannot get involved in divorce and custody matters.**

Thank you for understanding our financial policy. Please let us know if you have questions or concerns.

I HAVE READ THE FINANCIAL POLICY AND UNDERSTAND AND AGREE TO THESE TERMS.

Please Print Name	Signature of patient or responsible party	Date