**DENTISTRY BY DESIGN**
**Richard A Coffman, DDS**
**2236 N Mitthoeffer Road**
**Indpls IN 46229**
**317-897-5093**

# FINANCIAL POLICY

**Thank you for choosing our practice as your health care provider. We are committed to providing the utmost in caring and quality treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to treatment.**

**WE ACCEPT CASH, CHECK, VISA, MASTERCARD AND DISCOVER. Use of other sources also accepted is credit unions, banks, finance companies, along with CARECREDIT.**

## Regarding Insurance

**Payment is due at the time of service. If you have dental insurance, we accept assignment of insurance benefits after co-payments and deductibles are met. Please supply us with a copy of your insurance plan book or insurance statements so that we can accurately ESTIMATE the portion of the bill not covered by insurance. The balance is your responsibility whether your insurance company pays or not. Your insurance is a contract between you and your insurance company.**
**If you choose to file your insurance yourself, we will grant you a 5% courtesy fee reduction, when the entire balance is paid in full at the time of service. You may pay with check or cash, and a completed dental insurance form will be provided for you to submit.**

## Usual and Customary Rates

**Our practice is committed to providing the best treatment for our patients and our fees are in the usual and customary range for our area. You are responsible for payment regardless of any company's arbitrary determination of usual and customary rates.**

**Initials________**

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## Missed Appointments

**In consideration for our patient's schedules, we ask that you only choose an appointment that you are sure you will be able to keep. We understand that emergency situations arise occasionally and will take that into account. We ask that you provide our office with a 24 hour cancellation notice, as we have that appointment reserved for you. In the event of a failed or canceled appointment less than 24 hours in advance, our office will assess a $50.00 fee for each hour scheduled.**

## Interest

**We reserve the right to charge interest in the amount of 1.5% per month (18%APR) for all balances not paid in full within 30 days.**
**By signing below, I understand this financial policy and agree to proceed with my dental care. I also agreed that a fee of $25.00 will be charged for all NSF checks returned to our office. Furthermore, I agree that if this account is turned over to an attorney or collection agency, I will be responsible for all reasonable collection fees equal to 25% of the delinquent balance, interest of 18% APR, court costs, and reasonable attorney fees. I also agree and assign any/all insurance benefits are paid directly to Dr. Richard A Coffman, DDS.**

**SIGNATURE__________________________________________DATE________**