APPALACHIAN DENTAL ASSOCIATES PC
William H. Dyer, Jr, DDS

Financial Policy & Payment Authorization

"Our commitment is to providing comprehensive dental care to the entire family through education and utilization of advanced technology."

About Methods of Payment

1. Cash, Check or Credit Card (MasterCard, VISA, American Express, Discover, & CareCredit)
2. Dental Insurance (Described below)

Dental Insurance

1. Our office will assist you in obtaining the maximum insurance benefits specified in your contract. However, your insurance contract is between you, your employer and the insurance company. **We are not a party to that contract.**

2. As a courtesy to you, we will file your insurance and accept assignment of benefits if you have signed the payment authorization form. Our policy requires that your estimated portion & deductible be paid at the time of service. In addition, we will file your primary & secondary insurance for you. The filing of **any other** insurance coverage will be your responsibility; **WE DO NOT FILE TO TERITIARY INSURANCE.**

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover. We would like to remind you that you are ultimately responsible for the service you receive. **We will pursue payment from your insurance company for your claim for sixty (60) days, after sixty (60) days you will be responsible for your balance in full.**

Related Policies

1. Returned checks and balances older than 30 days may be subject to additional collection fees & interest charges of 1.75% per month, or 21% annually. These additional fees will be applied to the unpaid balance at the end of the month.

2. In the unfortunate circumstance that you fail to pay & we are forced to refer your account to collections or our attorney, you will be responsible for all fees incurred for collection of your bill (i.e., attorney fees, court costs, collection agency fees, etc.)

3. **Your appointment time has been reserved exclusively for you. Any change in your appointment affects many patients. We reserve the right to charge a Cancellation Fee to those who do NOT SHOW or Short Notice Cancellations/Reschedules. A 24 Hour Notice is required to avoid being subject to this charge.**

I have read, understand, agree & accept the condition of these policies to receive care from this office (regardless of my insurance) I am responsible for any charges incurred from services rendered.

Name: (Please Print)_____

Signature_____ **Date**_____