Financial Policy

This page lists the financial policy for the office of Route 40 Family Dental. Please read carefully. By signing, you agree to the terms and conditions.

Patients with dental insurance should provide us with claim address information and insurance phone numbers for eligibility status. Your insurance contract is between you and your insurance carrier.
PPO and Traditional Insurance: We are extending you credit when we bill your insurance company rather than requiring full payment at the time of service. If you have a deductible, we request that you cover your deductible plus applicable co-pay percentage (ex: 20%).
HMO or Discount Dental Plans: These are reduced fee plans. There is no billing under these plans. The fees are reduced fees contracted through your insurance and are due in FULL at the time of service.

No Insurance: Payment is due in full at the time of service. If special arrangements need to be made, please speak to the Doctor in advance of your appointment.

Account Charges: All accounts must be paid in full within 90 days of service no matter what action your insurance company takes. A billing charge of $5.00 per month will be instituted for all accounts over 30 days old. A fee of $25 will be charged on all returned checks. A fee of $65 will be charged for broken appointments cancelled with less than 24 business hours notice. This will be **strictly enforced.**
Bills not paid in full within 90 days will be referred to a Collection Agency. Your account will be subject to a collection fee of 35%-50% of your balance. If your account requires legal action, you agree to pay all legal and attorney fees associated with the collection of your account.

The Undersigned hereby waives any defense he/she may have as to the Statute of Limitations barring future attempts to recover debts owed hereunder in the event of default.

Release of lnformation: Route 40 Family Dental may disclose any or all parts of the clinical record including portions by other providers to my (our) insurance company (s) for the purposes of satisfying charges billed by Route 40 Family Dental.

I, _____ hereby authorize Route 40 Family Dental to apply for benefits on my behalf for covered services rendered. I request payment from my insurance carrier and all third party insurance carriers be made directly to Route 40 Family Dental.
Guarantee of Account: For and in consideration of services rendered by Route 40 Family Dental to the below named patient, the undersigned jointly and severally guarantees payment of such bills.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

_____ _____
Patient Date

Patient/Guarantor Signature:_____
(If patient is under 18 yrs old)