Financial Policy

Michael L. Crowton D.D.S.
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Our office maintains that every patient is entitled to the highest quality of dental care that can be provided. Your health and well-being are our primary concern. We appreciate the consideration you must give to the cost of your care. The financial obligations for the treatment we render to you are your responsibility. We welcome and encourage frank discussion of services and fees prior to treatment.

This is an agreement between Dr. Michael Crowton, as a creditor, and the Patient/Debtor named on this form. By executing this agreement, you are agreeing to pay for all services that are received.

Insurance:
Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

It is the patients' responsibility to know who the preferred provider is for their insurance company.

Monthly Statement:
If you have a balance on your account, we will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month. If you have any questions or concerns you may always contact us.

Payments:
Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the 13th of the month.

Payment Options with no Insurance:
Cash, Check, Money Order, Visa, Mastercard, Discover, American Express
-10% discount paid at the time of service.
-On extensive treatment you may want to secure financing outside of our office so that you may ensure that you are receiving the lowest interest rate possible.
-Care Credit (ask us about it)

Payment Options with Insurance:
-Pay any relevant deductibles or non-covered services at the time of service, and any remaining portion is due and payable after insurance has paid.
–On extensive treatment (crowns, bridges, dentures, etc.) you may pay 50% of your estimated portion at the preparation date and the remaining 50% of estimated portion at delivery date, or all of it at the delivery date.

Waiver of Confidentiality:
You understand that if this account is ever submitted to an attorney or outside 3rd party, the fact that you received treatment at our office may become a matter of public record.

PLEASE TURN OVER AND SIGN

Charges to Account:
We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Divorce:
In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Finance Charge:
A finance charge will be imposed on any unpaid balance after 60 days and is subject to 1½ % per month or an annual percentage rate of 18%. The minimum charge is .50 cents.

Past Due Accounts:
If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to an outside 3rd party, you agree to pay all of the collection costs which are incurred. 40 % of the account balance will be added to your bill at the time it is sent to collections. In addition to paying the above, if we have to refer collection of the balance to an attorney, you agree to pay all attorney fees which may occur with or without suit, plus all court costs.

Patient's Name :_____
(Print)
Responsible Party:_____
(if not the patient)

Signature of Responsible Party:

_____

Returned Checks:
There is a fee (currently $25.00) for any checks returned by the bank.

Missed Appointment Fee:
Any appointments that are cancelled or otherwise broken without a 24 hour notice are subject to a $25.00 missed appointment fee.

Transferring of Records:
If you would like us to send a copy of your records to another doctor or organization, you may either call, fax, or send a written request. By requesting this transfer you will be authorizing us to include all relevant information, including payment history.

Worker's compensation:
We require written approval by your employer and /or worker's compensation carrier prior to your 1st visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury:
If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your 1st visit. Payment of the bill remains the patient's responsibility.

Effective Date:
Once you have signed this agreement you agree to all of the terms and conditions contained herein.

Date:_____