Perio Aesthetics & Implantology, LLC.

Angela L. Blizzard, DMD

FINANCIAL POLICY

We are committed to providing each patient with the best possible care. If you have dental insurance, we will help you receive your maximum allowable benefits. In order to do this, we need your assistance, and your understanding of our financial policy.

REGARDING NON-INSURED PATIENTS:

Payment in full is due at the time of service.

REGARDING INSURED PATIENTS:

The estimated non-insurance portion (co-pay) for treatment rendered is due at the time of service. While the filing of insurance claims is a courtesy to our patients, all charges are your responsibility from the date the services are rendered. If your insurance company has not paid on your account in 90 days, the balance will be expected in full.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance; however, please understand:

- Your insurance is a contract between you, your employer, and the insurance company. We are NOT a party to that contract, and we are not a preferred provider of any insurance company.
- Not all services are a covered benefit. Insurance companies select certain services *they* will not cover, which often include bone grafting, implants and sinus surgery.

We accept cash, check, Visa, MasterCard, American Express, or Discover Card. Information regarding extended payment plans through Care Credit is also available. Returned checks will be subject to an additional fee of $ 25. Accounts over 60 days will be subject to a monthly finance charge of 1.5%.

If you have any questions about the above information or are uncertain regarding insurance information, PLEASE do not hesitate to ask us. We are here to help you. Surgical procedures require 48 business hours to cancel, or they will be subject to a fee of $150. Procedures requiring Bio-4 bone grafting will be subject to a $500 deposit due to shipping and shelf life restrictions. *Please note we are closed on Mondays.*

I understand and agree that (regardless of my insurance) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on this sheet.

NAME (please print) ____

SIGNATURE ____ Date ___________________

PARENT/GUARDIAN (if minor) _________________________________ Date ___________________