Graham McCabe
FAMILY DENTISTRY

Financial Policy

We are committed to providing you the best possible care. Our office is in the Assurant Alliance Group, for the following: Aetna, Ameritas, Assurant, BC&BS, Sunlife and United Concordia. The above must be in the Alliance Group for us to be in-network. We are also in-network with Delta Dental as a Premier Delta dentist only. We are not in-network with more insurance plans due to the limitations they attach to treatment, regardless of the doctors' diagnosis. Our commitment is with you, our patient, not to any insurance company.

We offer several options regarding financial arrangements for treatment.

- As a special service to you, we offer a **5% cash courtesy** if you pay for your entire **treatment plan in full**, on day service is rendered if paid by cash or check only. (Applicable for private pay patients only.)
- Payment by appointment (this option lets you spread out payment according to treatment plan)
- Payments made in full by Visa, Mastercard, Discover and American Express
- For payment arrangements for three months, a credit card must be left on file and the card will be ran on the 1st, 15th, or 31st of the month.
- For any **payment arrangements longer than 3 months**, we offer a healthcare financing program, which when you are accepted, will allow extended small monthly payments for the treatment received. (**Care Credit**)
- Payment of **estimated** patient portion and **filing Dental Insurance**
  - We will file an insurance claim on your behalf as a courtesy to you, however you must supply all necessary information needed for filing.
  - Any deductible as well as estimated portion your insurance does not cover are to be paid on the date of treatment rendered.
  - It is the patient's responsibility to know the details of the insurance coverage including pay tables, waiting periods, deductibles, yearly maximums, services not covered etc.
  - **If your insurance company has not paid their liability in 60 days, then the balance becomes the patient's liability.**
  - Your insurance policy is a contract between you and your insurance company and the financial responsibility for your treatment is yours whether your insurance pays or not.

I understand that it is the policy of this office to require at least 24 hours advance notice for any cancellation or scheduling changes. Failure to do so will result in a fee of $50.00.

Print Name: _____

If not the patient relationship to the patient: _____

Signature: _____ Date: _____