



Robert Earl Barberee, BS, DDS, PC

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OUR FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. We are committed to providing you and your family with optimum dental care. Please understand that payment of your bill is considered part of your dental treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any dental treatment.

Payment is expected at the time of service:

We accept cash, checks, Visa, Mastercard, Discover, and Care Credit cards. If you have the need to carry your financial commitment over a period of time, we can assist you in obtaining financing.

Minor patients of divorced parents:

A divorce decree is a legal agreement binding only upon the two parties who made the agreement. Regardless of whom the judge deemed financially responsible for dental bills, the parent who brings the child to the office for dental treatment is responsible for payment at the time of service. The parents can settle the financial responsibilities between themselves. Do not ask us to do this for you.

Dental Insurance:

We will accept your insurance as partial payment for you or your families dental treatment provided you have the following:

- 1) *Proof of insurance coverage.*
- 2) *An insurance policy submission form for each member of your family undergoing dental treatment with all required information completed.*
- 3) *An insurance plan/form that provides for assignment of benefits to our office.*
- 4) *Signature of the insured wherever necessary.*
- 5) *Proof that your deductible has been met.*

If you do not provide us with this information you will be responsible for all charges.

Interest charges and Collection Agency

I understand *payment is due in full at the time of service* and there is a *\$25 charge for returned checks*. I also understand that no balance, including insurance billings, shall not be carried by this office for more than 60 days of the date of service. If payment is not completed within 60 days, this office will be forced to turn my account over to a collection agency. All collection charges shall be paid by the patient (or responsible party) and this office will not be held liable for any damage done to my credit rating. All unpaid accounts are charged 1.5% of the outstanding balance per month, which is equal to 18% per year.

I have read and understand this entire page prior to signing below.

Patient _____

X _____
Person responsible for account if different from above