Robert Earl Barberee, BS, DDS, PC

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Stephenville, TX 76401
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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 as a non-contracted out of network provider for you or your family's 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. Under this arrangement, you are responsible for paying your co-pay, any non-covered portions, and any deductibles. In addition, if your insurance company does not pay for our services, you agree to pay for the services rendered.

Cancellation/No Show Policy:

Our goal is to provide accessible high quality care. In consideration of the time and in fairness to our other patients and providers; we require 24 hour notice when cancelling or rescheduling an appointment. We understand that life has unexpected changes, often times at the last minute. As such, after the second occurrence of a no show or late canceled appointment, there will be a $100 per hour fee. A nonrefundable deposit will also be required to reschedule the appointment which will be applied to the patient responsibility portion of the visit or retained for the cancellation fee if you fail show or provide inadequate cancellation notice. This office reserves the right to dismiss patients with excessive cancelled appointments.

Interest charges and Collection Agency

I understand payment is due in full at the time of service and there is a $30 charge for returned checks. I, the undersigned, understand and agree that there will be an interest charge of 1.5% per month of any past due account over thirty days. I also understand and agree that if I am in default of this agreement, my balance will be sent to a collections agency and I will be responsible for all costs incurred to collect my delinquent account. My increased balance will be calculated by dividing my current unpaid balance by (.75). In the event an attorney would be required, my unpaid balance would be divided by (.50). 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.

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

Print Patient Name_____

X_____ Date _____
Person Responsible for Account