CORNERSTONE
DENTAL

INSURANCE AND FINANCIAL POLICY

At Cornerstone Dental, we believe that you deserve the best care and we are committed to using the latest technology and highest quality materials to help ensure your treatment is successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

Initial

_____ ■ **Cornerstone Dental does require payment in full for your portion at the time of service**. We accept cash, checks, MasterCard, Visa, American Express and Discover. Please note that any returned check will have a fee of $35 added to your account. If you are in need of an extended financing option, we also work with CareCredit, which offers affordable monthly payment plans.

_____ ■ We currently are in-network with many dental insurance plans. Although we maintain fee schedules and reimbursement rates for each insurance plan, they do change from time to time; therefore it is impossible to provide a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like a more accurate estimate of your out-of-pocket expenses, we would be happy to file a "pre-treatment authorization" with your insurance company prior to treatment, however, this could delay treatment.

_____ ■ We will bill your insurance as a courtesy. If insurance does not pay within 90 days, Cornerstone Dental reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office. If you have any questions regarding your dental benefits please contact your employer or insurance company directly.

_____ ■ A service charge of 1.5% per month will be added to all accounts 30 days or older.

_____ ■ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24-hour notice to avoid a $35 cancellation fee.

I have read, understand and agree with the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself (or my dependents) is mine, and is due and payable at the time services are rendered.

Print Name:_____Date:_____

Patient/Parent Signature_____