Financial Acknowledgements and Office Policies

Patients with Dental Insurance: As a courtesy, we will file dental claims for you. Since most plans cover only a portion of the fees for your dental care, we expect payment at the time of service for your deductible and the portion that we estimate insurance will not cover. Your payment portion for fillings is usually 20-35% and for crown and bridge services it is 50-60%. This office can make no guarantee of the insurance payment as estimated, even in the case of a pre-estimate. If your insurance claims remain unpaid for more than 30 days, we may ask for your assistance. After 45 days, we will ask for full payment from you. You may then request reimbursement from your insurance company. We are not a contracted provider of most insurance; however; we do accept all insurance that provides coverage to out of network dentists. It is your total responsibility and obligation to know what your insurance benefits are. Dr. Fortson's office will not enter into a dispute with your insurance company.

Patients without Dental Insurance: Crown, bridge, veneer, and denture services require 50% payment the first visit and the balance is required prior to the second visit. If payment is not received in full, your appointment will be rescheduled. For all other services, payment in full is expected at the time service is rendered.

Payment Options: You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance plan. If we have not received payment from your insurance company within 45 days from date of service, you will be expected to pay your balance in full. Ultimately, you are responsible for all services rendered. You will receive a statement indicating what your insurance paid toward services rendered. Any remaining balance is due upon receipt of statement. For your convenience, we accept cash, personal checks, money orders, and all major credit cards. Extended payment agreements may be arranged prior to treatment with our outside financial partnerships. We are proud to offer financing payment plans with Care Credit. Any unpaid balance over 60 days will be subject to a 1-1/2 % per month (18% Annual Percentage Rate) charge.

Missed Appointments/No Shows: Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Our appointments are scheduled to respect your time. We reserve a specific time for your care and we make every effort to see you at that appointed time. We appreciate your promptness and consideration in not changing your scheduled time. However, if you do need to change an appointment, please give us a 48 hour notice.

Refunds: Overpayments will be refunded upon request to the responsible party within 30 days. Otherwise, any overage will remain as a credit on your account.

Fees: Fees quoted will be honored for 90 days.

Returned Checks: A $30 charge will be incurred to your account for any check returned by your bank for any reason.

I have read and understand the Financial Polices and Procedures of the Office of D. Keith Fortson, D.M.D, P.C. I agree to assign insurance benefits to D. Keith Fortson, D.M.D, P.C. when necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will be responsible for an additional 30% of the balance for collection costs incurred.

Patient or Guardian Signature_____ **Date**_____

Financial Coordinator_____