



KEVIN C. DICKINSON<sup>D.D.S.</sup>  
**DENTISTRY**

**ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE**

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

**Payment** for services is due at the time services are rendered unless payment arrangements have been approved in advance by my staff. We accept cash, checks, MasterCard, or Visa. We will be happy to submit your insurance claim-form for reimbursement.

**Returned** checks and balances older than 30 days are subject to additional collection fees and interest charges. Charges are also made for broken appointments, no show of appointment, or cancellation of appointment without 24 hours advanced notice. We will gladly discuss your proposed treatment/finances and answer any questions relating to your insurance.

**You must realize, however, that:**

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (50% or 80%) of "U.C.R.", "U.C.R." is defined as usual, customary, and reasonable.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that, as dental care providers, our relationship is with you, not your insurance company. The filing of insurance claims is a courtesy that we extend to you, all charges are your responsibility from the date the services are rendered.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us. We are here to assist you.



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PLEASE READ CAREFULLY AND SIGN

**Our Office Policy**

Thank you for choosing us as your dental care provider. My staff and I are committed to your positive treatment outcome. Please remember that a commitment from you is also a very important part of your treatment. If you have any questions about any of the following, please feel free to ask questions of any staff member.

**Regarding Insurance**

As a courtesy to you, we accept assignment of insurance benefits from most insurance companies. **HOWEVER**, we do require that you pay your estimated portion at the time of service. The balance is your responsibility whether your insurance pays or not. You must make sure that we have your current insurance information on file. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

**Usual and Customary Rates**

We are proud of our fees, they reflect the quality of treatment that you receive. Regardless of any insurance company's arbitrary determination of usual and customary rates, you are responsible for payment.

**Appointments**

Your appointments are scheduled to respect your time. We reserve a significant amount of time and reserve a specific room for your care and make every effort to see you at that appointed time. We appreciate your promptness and consideration in not changing your reserved time. However, if you do need to change an appointment, a 24 hour notice is expected. A fee may be applied for appointment missed without notice.

**Minor Patients**

The adult accompanying a minor (under 18) is responsible for full payment. Arrangements must be made in advance if a minor child is seen without an adult.

**Payment Options.**

FULL PAYMENT IS DUE AT TIME OF SERVICE.  
WE ACCEPT CASH, CHECKS, VISA, MASTERCARD.

Thank you for understanding our guidelines. Let us know if you have any questions.

I have read the financial policy. I understand and agree to this financial policy.

X \_\_\_\_\_ Date \_\_\_\_\_  
Responsible Party