Lindner DENTAL
ASSOCIATES, P.C.

PAYMENT & FINANCIAL POLICIES

We are committed to providing you with the best possible dental care. *The patient or parent signing the financial agreement is established as the account holder for the family.* The account holder is not necessarily the insurance subscriber. The account holder accepts full responsibility for payment of all charges, including instances in which a divorce decree specifies shared responsibilities.

If you have dental insurance, we look forward to helping you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

We are participating providers with most Delta Dental ** plans. Payment for all non-covered services is due at the time services are rendered and we will submit claim forms directly to Delta Dental. **** Please note recent changes in Delta Dental insurance policies that may affect your coverage. ATTENTION PPO PATIENTS: PPO fees only apply when a PPO participating dentist is providing care. Not all of our dentists are PPO providers. Therefore, there may be additional out-of-pocket costs to you if a non-PPO dentist provides service to your family. Please initial here to acknowledge understanding:**

_____

We will be happy to help you in the processing of insurance claim forms to all other dental insurance carriers. Upon receipt of payment for services rendered, we will provide you with an itemized claim form to submit to your insurance company for reimbursement. **If you would prefer to have us submit claims directly to your insurance, please inquire about our Family Flex Plan.** Please remember that assisting you in the filing of insurance claims is a courtesy to you and all charges become your responsibility on the date services are rendered.

Payment is due at the time services are rendered. Budgeted contractual arrangements may be made in advance of treatment in case of extensive treatment needs. We accept cash, personal checks, Visa, Mastercard, Discover, and American Express. Balances older than 30 days will be subject to additional collection fees and interest charges of 1½ % per month. Returned checks will be subject to a fee of $41.00 in addition to any fees imposed by your bank. Charges will also be made for broken appointments and appointments cancelled without 24-hour advance notice.

We encourage you to discuss any financial concerns that you may have so that we may assist you in the effective management of your account.

We are here to serve your family's dental and orthodontic needs optimally, and to make the entire process a pleasant experience for all involved.

I HAVE READ, UNDERSTAND, AND AGREE TO THE FINANCIAL POLICY DESCRIBED ABOVE.

_____ _____
Signature of Responsible Party Date

_____ _____
Print Responsible Party's name Patient's Name(s)