Financial Policy

Thank you for choosing Luck Dental Clinic for your dentistry needs. Our patients are extremely important to us and we value your commitment to us as your dental provider.

The following is a summary of our financial policy that will apply to you and all of your dependents:

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE

Payment is required at the time service is rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. Luck Dental Clinic accepts cash, personal checks, Visa, Mastercard, Discover and American Express. We also accept Wells Fargo and CareCredit, which are medical line of credits that can help with payment of dental services upon approval. **Important:** There is a $35 service charge for all returned checks.

Patients with an outstanding balance of 60 days or more must pay balance in full and/or make arrangements for payment prior to scheduling future appointments.

INSURANCE:

Luck Dental Clinic does bill participating insurance companies as a *courtesy* to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

ACCOUNT FLOW:

You will receive statements if a balance is due. If arrangements are not made and if account is not resolved, your account may be turned to our billing service and/or to a Credit Reporting Agency. You are responsible for any additional fees rendered such as, but not limited to, collection fees, interest and legal fees.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

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. Cancellations are requested 24 hours prior to the appointment. Luck Dental Clinic reserves the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand Luck dental Clinic's Financial Policy. I agree to assign insurance benefits to Luck Dental Clinic whenever necessary. I also agree that if it becomes necessary to forward my account to a Credit Reporting Agency, in addition to the amount owed, I also will be responsible for any fees charged by the Credit Reporting Agency for any additional costs.

Signature of Patient/Guardian: _____ Date: _____