Arizona Dental Medicine, P.L.L.C.
FINANCIAL POLICY

Patients
Thank you for choosing Arizona Dental Medicine, PLLC (AZDM) as your dental health care provider. The doctors and staff at AZDM are committed to providing you with the very best dentistry possible. Please understand that payment for services is considered part of your treatment. As a condition of treatment, financial arrangements must be made in advance. Payment is due at time of service. We accept cash, check, and all major credit cards (except American Express) as methods of payment. Outside financial assistance, including interest free financing, is available for those who qualify.

Patients who are Minors
For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Credit Card, or payment by cash or check at the time service has been verified.

Missed Appointments ____ (Initial)
Appointments are set-aside just for you. Treatment rooms are prepped just for your appointment. At least 48-hour business day notice is required to avoid a cancelled or missed appointment charge of $50 per hour scheduled. Please help us serve you better by keeping scheduled appointments.

Regarding Insurance ____ (Initial)
Per your authorization, we may accept assignment of insurance benefits following verification. Your authorization is irrevocable for any treatment performed by the doctor and shall include the release of any necessary medical information to the insurance company. AZDM will assist in collecting from the insurance company and filing the necessary insurance forms, however, this office cannot render services based on the assumption that charges will be paid by the insurance company. In acceptance of the assignment of benefits, we do ask for a credit card to be placed on file. In carrying dental insurance, all dental services furnished are charged directly to the patient and he or she is directly responsible for payment of all dental services regardless of insurance benefits. Please be aware that some, or perhaps all, of the services provided may be considered non-covered services or beyond reasonable and necessary under dental insurance plans. It is the patient's responsibility to understand the terms and provisions of his or her dental insurance plan. If your insurance company has not paid your account in full within 60 days, the balance will be automatically transferred to the credit card on file.

Financial Responsibility ____ (Initial)
A statement processing fee of $5 and a finance charge of 1.5% will be assessed on ALL accounts over thirty (30) days as authorized by state law. All accounts sixty (60) days past due may be forwarded to a collection agency and subject you to all collection and attorney fees. You understand and agree, whether signing as an agent or as a patient and whether insured or a member of a health maintenance organization, that in consideration of the services to be rendered, that you hereby individually obligate yourself to pay the account of the medical facility in accordance with the regular rates, terms and interest on the unpaid balance set out by the facility. You understand that you will be responsible for eighteen percent (18%) per annum interest on the unpaid balance if my account becomes delinquent. In the event that it is necessary to place the account with a collection agency to collect the balance due, an additional 50% of the principle balance due will be added to defray the cost of collection. In addition, should legal action become necessary to collect the balance due, you understand that you will be responsible for reasonable attorney's fees, interest and court costs. You also understand that if your account is placed with an agency for collection or placed with an attorney for legal action that a credit report will be pulled for the sole purpose of collecting the delinquent account. A credit card on file may enhance your protection against collection and attorney fees by authorizing the transfer of all unpaid amounts to your credit card after 60 days from the date of services. By signing below, you state that you have read, understand, and agree to this Financial Policy.

Financial Selection (Initial Preferred Option)

____ I would like AZDM to accept assignment of benefits and assist in filing necessary insurance forms. I understand that I am responsible for payment of all services regardless of insurance benefits and that there is a $5.00 statement processing fee and a 1.5% finance charge on all accounts over thirty (30) days.

____ I would like to avoid all billing fees and pay my account in full at time of service. If carrying dental insurance, I would like AZDM to provide me with a copy of a completed claim form that I can mail into my insurance company for direct reimbursement.

Credit Card # _____ **V Code** _____ **Exp Date**_____
Visa / Master Card / Discover / Care Credit

Signature _____ **Print Name** _____
(Patient or parent or legal guardian if patient is a minor)