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OF OWENSBORO
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Financial Policy

We at Dr. Booker's are pleased you chose us to care facilitate and care for your dental health needs. In order for us to keep costs as low as possible for you, we require payments are made at time of service. Please understand that payment of your bill is considered part of your treatment. The following is statement of our financial policy, which we require that you read, agree to, prior to any treatment.

Payment Options:

- We accept Cash, Checks, Master Card, Visa, Discover, and Bank debit cards.
- We offer a **5% discount** to our patients who choose to pay in full at time of service with cash or check.
- We offer extended payment plans with no interest through third party financing with Care Credit to those who qualify. It offers flexibility and low payments for those who prefer low monthly payments.
- Those with insurance can take advantage of the same **5% discount** if they pay for the treatment in full and accept to be reimbursed by their insurance company. (Excluding Delta Dental Premier, Health Resources (HRI), and Dentemax).
- Other financial arrangements are reserved for major work to be performed over $2000. We will be happy to discuss these options with you if the situation applies.

Insurance:

For those patients who have financial assistance from insurance, your estimated co-insurance amount is due at this time. We will continue to submit your claims for you; however, your insurance is a contract between you, your employer, and the insurance company. As your dental provider, our relationship is with you, not the insurance company. All charges incurred are the responsibility of the patient regardless of your insurance coverage. We will cooperate fully with the regulations and requests or you insurance company that may assist in your claim being paid. Disputes or denied claims should be directed to your insurance carrier and / or employer. Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 30 days, we will ask that you contact your insurance to make sure payment is expected. If payment is not received within 60 days from the date of filing, or your claim is denied, you will be responsible for paying the full amount at that time. If we receive any payment from your insurance company after you have paid your bill in full, we will remit the payments directly to you.

Treatment Plans

Treatment plans for any dental treatment is good for 90 days after that, fees are subject to change.

Emergency Patients:

For emergency patients who are not a patient of record, we will file any insurance claims, but require payment in full. Once you are a patient of record, we will then only require your co-insurance.

Minors with Separated or Divorced Parents:

When two parents are each responsible for one half of the cost of a child's dental care,

the Parent or guardian who brings the child is responsible for the co-insurance or the full fee. They will also be responsible for collecting payment from the other parent.

Returned Checks / NSF:

A $50.00 fee will be assessed for all returned or NSF checks. We reserve the right to reject check payments once a NSF occurs.

Short Notice Cancellations and Broken Appointments:

Each appointment is a reserved time for you and you only. Each time appointments are not kept; other patients who do value their reserved time for treatment are penalized. A $40.00 fee or more may be assessed for cancellations without a 48 hour notice or a missed appointment. We reserve the right to decline future appointments unless paid in full. We may also require your next visit be secured with a credit card deposit. The office situation will determine what time this occurs.

I have read and understand the financial policies of Dr. Booker's Office. I understand I am responsible for all fees incurred for my dental treatment.

_____ Patient initials

I understand insurance plans are payment assistance plans; they are not designed to cover the entire cost of treatment. I understand my insurance carrier may pay less than the actual bill for services. By signing this form I have authorized assignment of benefits directly to Dr. Booker and this practice.

_____ Patient initials

I understand I am responsible for any and all charges that might occur if my account is turned over to our collection agency.

_____ Patient initials

Signed: _____*Date*: _____/_____/_____

Parent
Or / Guardian of: _____
Childs Name if applicable