Financial Policy of Ian Rothbauer, DMD

Thank you for choosing our office as your dental health provider! Our primary responsibility is to provide the highest quality dental care for you and your family. Part of our commitment is to ensure you understand and are responsible for the payment of your account balance.

Full Payment is Due at Time of Service

Payment arrangements can be made on a case-by-case basis if extensive treatment is planned and approved by our Office Manager. If approved, a payment agreement will be signed.

Minor Patients

The adult accompanying a minor and the Parents/Guardians are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized by Credit Card, Cash, or verified Check.

Emergency Visits

All emergency dental services must be paid for at the time services are performed.

Patient Responsibility and Additional Terms

- All unpaid balances are subject to a delinquent fee of $35 and a 1.5% monthly (18% Annual) finance charge.
- If we have to submit your unpaid account to our collection agency for recovery, you will be responsible for all charges our practice incurs, including but not limited to collection fees, court costs, and reasonable attorney's fees.

Returned Checks

Any returned check will carry a $50 fee in addition to the balance already owed.

Patients with Insurance

If you have dental insurance, we are happy to help you receive your maximum allowable benefits if you supply your insurance card or insurance plan before the day of treatment.

- We ask that you read your policy to be fully aware of any limitations of the benefits provided.
- We accept payment directly from the PRIMARY and SECONDARY insurance companies for the percentage (%) your insurance will cover. However, we require that the deductible and estimated non-covered fees from your Primary and Secondary insurance be paid at each visit.
- If the payment from the insurance company has not been received within 30-60 days, the insurance claim will be closed, and the patient is responsible for the balance.

It is important to realize:

1. Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance as a courtesy to you.
2. Not all dental services are covered benefits in all contracts.
3. You (not the insurance company) are responsible to us for all our fees for services.
4. An estimate can be given of the benefits that the insurance company is expected to pay and any co-payment that is expected at the time services are rendered, if requested.
5. A secondary insurance does not necessarily mean that your entire treatment will be covered.

Your appointment time has been reserved especially for you. There is a 36-hour notice required to cancel or postpone an appointment.

Missed or Broken Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge a non-refundable $65.00 fee for missed appointments and short-notice cancellations. Please help us serve you better by showing up on time for your scheduled appointments! If you are more than 10 minutes late for your appointment, it is considered a NO SHOW, and you will be asked to reschedule as this delay affects not only Dr. Rothbauer, but other patients scheduled after you.

Our entire staff is dedicated to you, the patient. Please let us know if you have any questions or concerns.

Acknowledgment

I have read, understand, and agree to the above Financial Policy of Ian Rothbauer, DMD. I authorize payment of dental benefits to be made to Ian Rothbauer, DMD (DBA Rothbauer Dental) for services rendered to myself or my dependents covered under my insurance. I further authorize the release of any information acquired in the course of my exam or treatment to my authorized insurance carrier or referring physician or dentist to facilitate the payment of a claim. I am aware of and decline a copy of The Notice of Private Practices/HIPAA. It is posted in the office or can be accessed online.

Please fill in card information below:

- *Check One:* ( ) Visa ( ) MasterCard ( ) Discover
- *Card Number:* ---
- *Expiration:* /
- *CVC:* _____

Permission is hereby given to refund your card if we over-collect on your copayment, as well as to automatically charge your card for any remaining balance.

- *Printed Name:*_____
- *Signature:*_____
- *Date:* _____

INDICATES CLEAR UNDERSTANDING AND ACKNOWLEDGMENT OF THIS OFFICE POLICY.