OUR FINANCIAL POLICY

Thank you for choosing Dr. Tourkakis for your dental needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following statement is our Financial Policy, which we require you read and sign prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECK, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS AND OFFER 3, 6, 12 AND 18 MONTH INTEREST FREE FINANCING FOR THOSE WHO QUALIFY.

There is a $15 handling fee for any returned check. Attorney and collection fees incurred in an effort to enforce payment will be the responsibility of the patient/guarantor. Failure to sign this contract does not negate the responsible party from financial responsibility for any services that have been rendered, as submission of treatment implies consent as outlined in this agreement. We reserve the right to charge interested in the amount of 1.5% as provided by state law.

FOR PATIENTS WITH INSURANCE: As a service to our patients, we will accept "assignment of benefits" and will bill your insurance carrier, provided all necessary insurance information is provided to our office at the time of service. Every effort will be made to closely estimate your co-payments and deductibles that are due at time of service. Account balances are your responsibility whether the insurance company pays or not. It is our office policy to collect all co-insurance deductibles and non covered amounts at time of service. Please understand that insurance coverage and benefits are contracted between you and your insurance company. If an insurance carrier has not paid within 60 days of service (regardless of reason), any unpaid professional fees are due and payable in full from you. Again, all account balances, regardless of insurance status, are due within 90 days of service.

ADULT PATIENTS: Adult patients are responsible for full payment at time of service.

MINOR PATIENTS: The adult accompanying a minor and the parents (or guardians of the minor) is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard/Discover or payment by cash or check at time of service has been verified.

USUAL AND CUSTOMARY RATE: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary in our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MISSED OR CANCELLATION OF APPOINTMENTS: Our goal is to provide high quality of care at low cost to our patients and in fairness to other patients and Dr. Tourkakis, we require at least 24 hours notice when canceling an appointment. You may be liable for a $50.00 fee for missed appointments without 24-hour notification. The practice reserves the right to dismiss patients with excessive canceled appointments.

I have read and understood the above financial policy for payment of professional fees. I understand and agree that I AM RESPONSIBLE FOR ALL FEES FOR SERVICES PROVIDED TO ME as outlined above.

Patient Signature____ **Date**_____________________

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