Regency Dental Center

2474 S. Federal Highway, Stuart, FL 34994
(772) 220-7555

OUR FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read, agree to and sign prior to any treatment.

- **All patients must complete our "Patient Information Form" before seeing the doctor.**
- **Full payment is due at time of service.**
- **We accept cash, check and Visa/MasterCard or Discover.**

TREATMENT PLANS

Patients that require dental treatment are always given a written estimate of services that are recommended. We want our patients to understand what needs to be done and what the costs will be. Patients that are covered with a dental insurance plan and need treatment will have the treatment plan sent to the insurance company for a pre-determination of benefits before the treatment is begun. Usually this applies to treatment that is over $300. If the patient wants to begin the treatment before a written pre-determination has been received from the insurance company, the patient will be responsible for the entire fee, and then when the insurance payment is received, the patient will receive a refund.

REGARDING NSURANCE

We accept assignment of insurance benefits; however, the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information. Your insurance policy is a contract between you and your insurance company. We are not a part of that contract. If your insurance company has not paid your account in full within 45 days, the balance of your account will be due by you. Please be aware that some and perhaps all of the services provided may be *"non-covered"* services and not considered reasonable and necessary under your insurance.

MINORS

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

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal visit. Please help us serve you better by keeping scheduled appointments.

RETURNED CHECKS

There will be a service charge of $50 for returned checks.

Thank you for understanding our financial policy. One of our goals is to reduce the cost of billing and thereby keep the costs of our services as low as possible to all of our patients. Please let us know if you have any questions or concerns.

I have read, understand and agree to the above financial policy.

Patient or Responsible Party_____ **Date**_____

Co-Responsible Party_____ **Date**_____