

Mark Kupec D.D.S., P.C.

## Our Service Agreement

Dear Patient,

We appreciate you choosing our office as your dental health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatment needed to maintain your dental health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask for our assistance.

We ask that **all** patients read and sign our Financial Policy as well as complete our Patient Information Form Prior to seeing the doctor.

Payments for services are due at the time of treatment. We accept cash, checks, and for your convenience, Visa, Mastercard, Discover and Care Credit. For patients who are children of divorce, the parent or guardian who brings the child to the appointment is responsible for payment.

As a **courtesy** to our patients, we will gladly file your insurance claims as long as we have the most current insurance information.

By signing below, you authorize Mark Kupec, DDS, and PC to accept **1. Assignment of Primary Insurance** and **2. Release of Information** as necessary requirements to process your claim as outlined by your insurance policy. However, you must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are **Not** a party to that contract. Our relationship is with you alone.
2. All charges are your responsibility whether your insurance company chooses to pay or not. Not all services are covered benefits in all contracts. Some insurance companies pick and choose which services they will cover.
3. All estimated charges along with unpaid deductibles are due at the time of treatment.
4. If the insurance company does not pay your balance in full within 60 days of date of service, we require you to pay the balance with cash, check or credit card.
5. Returned checks are subject to a \$35 charge.
6. Balances older than 60 days may be sent to an outside collection agency.
7. We do not accept payment from any secondary insurance carrier.

**If you are unable to keep any appointment, please give us 1 business day (Mon.- Thurs.) notice so the time that we reserved for you can be made available to treat another patient who is in need. We reserve the right to charge a missed appointment fee for appointments missed without adequate notice.**

**Any appointment 1.5 hours long or longer will require a deposit of 20%. The deposit will be applied to the appointment unless the appointment is missed without adequate notice.**

We understand that temporary financial problems may affect timely payment. Therefore, we encourage you to communicate any such problems so that we can assist you in the management of your account. **However, if your account becomes past due (after 30 days from the date of service), we will take all the necessary steps to collect the debt. If we have to refer your account to a collection agency, you agree to pay all the collection fees that are incurred.**

We appreciate your trust in us and hope to provide you with the ultimate care you deserve.

Patient/Guardian Address \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_