FINANCIAL POLICY

Thank you for choosing J. Michael Bellamy, DDS as your dental care provider. Our primary concern is that you receive the proper and optimal treatments needed to continue or restore your dental health. We hope that you understand that our credit and collection policies are a necessary part of assuring the financial resources needed to maintain our facility for our patients and community. Therefore, we have instituted the following financial policy. If you have any questions or concerns about our payment policies, please do not hesitate to contact our office. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information form prior to seeing the doctor.

1. Payment is due at the time services are rendered. We accept cash, checks, Master Card and Visa cards. In the case of insured patients, copays and unmet deductible will be expected to be paid at checkout.

2. We will be happy to process your insurance claim as long as you bring your current insurance card and provide accurate information for filing.

3. It is your responsibility to make sure that your have out-of-network benefits for your particular plan.

4. Your insurance policy is a contract between you, your employer (if applicable) and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company.

5. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. It is your responsibility to determine coverage limitations.

6. If your insurance company does not pay your balance in full within thirty (30) days of your visit, you hereby agree to contact the carrier to help speed payment.

7. Returned checks will be subject to the maximum allowed returned check fee.

8. All balances older than ninety (90) days will be reviewed and may be turned over to a collection agency. Any costs incurred in collection of an account may be added to the balance.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to contact our office so that we may assist you in the management of your account.

Again, thank you for choosing Dr. J. Michael Bellamy as your provider of dental services. We appreciate your trust in us and the opportunity to serve you.

Patient's Name _____

Guarantor's Signature _____Date _____

By my signature I indicate that I have read this policy, understand its content, agree to its provisions and am the party financially responsible for the above named patient.