PALM HARBOR
FAMILY DENTISTRY

Financial Options

Patient Name (PLEASE PRINT) ____ Date _________________

Accepted Methods Of Payment

1. Cash, Check, Credit Card, Care Credit or Health Flex Saving Card.
2. Dental Insurance, PPO Policy (Described Below)

Dental Insurance

1. We are pleased you have dental insurance, and our office will assist you in obligating the maximum benefits specified in your contract. However, your insurance contract is between you, your employer and the insurance company. Accurate insurance coverage information is required at the time of your appointment, or payment in full will be required.
2. As a courtesy to you, we will file your insurance and accept assignment of benefits if it's a policy we accept. We will determine to the best of our ability what your deductible and copayment will be. We ask that you pay that amount at time of service. There may be a balance due after the final insurance payment, that you are healed responsible to pay that balance in full.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover. If you wish to know if a procedure is covered prior to completion, you can request a predetermination or you can call your insurance provider with the code.
4. If in the case your insurance company does not pay for any specific procedure, you are healed responsible to pay the remaining balance in full.

Related Information

1. Returned checks and balances old than 90 days may be subjected to additional collection fees
2. In the event that the account is not paid and we refer the account to collections, you will be responsible for all fee incurred for the collection of your bill (i.e., attorney, court cost and collection agency fees)

Authorization / Acknowledgments

- I have read and understood the information above. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered. To the extent permitted by law, I consent to use and disclose my protected health information (HIPAA) to carry out payment and collection activities.
  Patient Signature ____ Date ________________

- I hereby authorize and direct payment of any dental insurance benefits to Palm Harbor Family Dentistry, PA
  Patient Signature ____ Date ________________