The Financial Policy of
Ian Rothbauer, DMD

Thank you for choosing our office as your dental health provider! Our primary responsibility is providing the highest quality dental care for you and your family. Part of our commitment is your understanding and responsibility for the payment of your account balance.

Our basic Financial Policy is the following:

FULL PAYMENT IS DUE AT TIME OF SERVICE

Payment arrangements can be made on a case-by-case basis if extensive treatment is planned and approved by our Office Manager. If payment arrangements are approved, a payment agreement will be signed.
We accept payments via Cash, Check, Debit Cards, Credit Cards (Visa, MasterCard, Discover), and third-party financing through Lending USA.

MINOR PATIENTS

The adult accompanying a minor and the Parents/Guardians are responsible for full payment at time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized by Credit Card, Cash, or verified Check.

EMERGENCY VISITS

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for the quality of the treatment that is rendered. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We will do all that is reasonable and proper to have you receive the maximum insurance benefits you are entitled to.

PATIENT RESPONSIBILITY AND ADDITIONAL TERMS

Accounts unpaid after 60 days from the date of service are subject to a delinquent fee of $35.00. Furthermore, the unpaid balance is subject to a 1.5% monthly (18% Annual) finance charge. If we have to submit your unpaid account to our collection agency for recovery, you will be responsible for all charges our practice incurs; including but not limited to collection fees, court costs, and reasonable Attorney's fees.

RETURNED CHECKS

Any returned check will carry a $50 fee in addition to the balance already owed. If more than one returned check is received on your account, we will require that future payments be made via Cash, Cashier's Check, or Credit Card. **Please remember that when you receive our statements, you have already received quality care from our Dentist and your insurance has been filed by us. We would then ask that you pay promptly upon receiving your statement.**

Our entire staff is dedicated to you, the patient. Please let us know if you have any questions or concerns. I have read, understand, and agree to the above Financial Policy of Ian Rothbauer, DMD. I authorize my insurance benefits be paid directly to Ian Rothbauer, DMD (DBA Rothbauer Dental). I authorize the release of pertinent dental information acquired during my evaluation or treatment to my insurance company or referring Physician/Dentist when requested, or to facilitate payment of a claim.

***Initial: _____ *Date: _____**

We understand and appreciate your concerns regarding the fees associated with your treatment and feel it is your right to have a clear understanding of your financial commitment to our office. We will be happy to discuss fees and provide estimates for proposed services any time prior to rendering services. With today's economy and current state of healthcare reform, we feel it is vital that not only our office, but YOU as our patient, fully understand the mutual obligations and responsibilities we have to each other.

PATIENTS WITH INSURANCE
Insurance co-payments MUST BE PAID AT THE TIME OF SERVICE. We will make every effort to provide you with an accurate ESTIMATE of your co-payment. As a courtesy to you, we will complete and file your insurance claim for treatment rendered in our office. However, you must realize that professional services are rendered to YOU, our patient, not to your insurance company, and as such, payment is your responsibility. Please remember that dental insurance is not designed to pay for everything. We urge you to read your policy. We will do our utmost to see that you receive maximum benefits within the structure of your dental plan.

Please Initial One:
We would like to have your permission to refund your credit card if we over-estimate your co-payment OR automatically charge your credit card for any balance due under $100.00:

****Initial_____***

The above, AND if your remaining balance is over $100.00 and you would like us to pay your balance off with you credit card:

****Initial_____***

****Please Circle One:*** Visa MasterCard Discover

****Card Number: _____-_____-_____-_____ *Expires: ____/____ *CVC: _____***

UNINSURED PATIENTS
Payment for services is expected at time of treatment. To assist you, we offer several options for payment: Cash Payment Credit Card - Visa or MasterCard Personal Check

MISSED or BROKEN APPOINTMENTS
Unless cancelled at least 24 hours in advance, our policy is to charge $50.00 for missed appointments. Please help us serve you better by keeping scheduled appointments. If you are over 10 minutes late to your appointment, it is considered a NO SHOW and you may be asked to reschedule as this delay affects not only Dr. Rothbauer but other patients that are scheduled after you.

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES, AUTHORIZATION OF INSURANCE BENEFITS AND RELEASE of DENTAL INFORMATION: I authorize payment of dental benefits to be made to Ian. Rothbauer, D.D.S. for services rendered to myself or my dependents covered under my insurance. I further authorize release of any information acquired in the course of my exam or treatment to my authorized insurance carrier or referring physician or dentist.

****Printed Name: _____***

****Signature: _____*DATE_____***

INDICATES CLEAR UNDERSTANDING AND ACKNOWLEDMENT OF THIS OFFICE POLICY.