Ann Fay Periodontics
Financial Policy

General

Thank you for choosing our practice as your periodontal care provider. Our fees reflect the quality of care you receive and the time spent with each patient. Please understand that payment of your bill is considered a part of your treatment. You will be required to pay your estimated portion at the time of service. If you do not have insurance, full payment is expected at the time of service.

WE ACCEPT CASH, CHECKS, VISA, OR MASTERCARD.

We also offer flexible financing through Care Credit.

Fees are valid for 30 days and are subject to revision. Treatment could be altered if your periodontal needs change. The patient will be notified of any change (s) in treatment.

INSURANCE

Insurance coverage is a contract between you and your insurance company, not our office. When you provide us with your insurance information, we will file or assist filing your claim for you. You are responsible for any balance that your insurance company does not pay. If payment is not received in 60 days, you are asked to take care of your balance and contact your insurance company. We will do our best to help you get benefits from your insurance company; however you are always responsible for your account balance. At this time we are in-network providers for **Delta Dental**, **Guardian, Blue Cross Blue Shield of Kansas City, MetLife** (Shawnee office only) and **Cigna**.

SERVICES

We will give you a detailed estimate of the anticipated charges. Our periodontal consultation fees range from $96-$265. Surgical procedures range in price from $450-$2111. If a surgical procedure is necessary, we will provide you with an individualized estimate. Payment arrangements will be made prior to beginning treatment.

MINORS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. Minors must be accompanied by an adult.

MISSED APPOINTMENTS

Appointment times are reserved just for you and as a courtesy we would appreciate a **48 hour** notification of a change to our schedule. There will be a $50 charge for a missed appointment.

INTEREST/COLLECTION FEES

We reserve the right to charge interest in the amount of 18% per annum as provided by state law. Patient will be responsible for all fees associated with collecting debt through an outside agency.

CONSENT

I understand and agree to this Financial Policy. I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form.

Patient Signature: _____Date_____
(Parent/Guardian if under 18)
Print Name_____