FORTSON DENTISTRY

FINANCIAL & PAYMENT RESPONSIBILITY POLICY

Thank you for choosing Fortson Dentistry as your primary dental care provider. We are committed to providing you with quality dental care. Below are the payment policies for our office. Please read, initial and sign in the spaces provided. If you have any questions, please feel free to ask. A copy can be provided upon request.

1. INSURANCE
   We participate with some insurance plans. If your insurance is not accepted, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

   _____ INITIAL

2. CO-PAYMENTS (PATIENT PORTION) AND DEDUCTIBLES
   All co-pays (Patient Portion) and deductibles must be paid at the time of service. Your co-pay (Patient Portion) is only an estimate. Occasionally, insurance companies do not pay all that is expected. When this occurs, the remaining balance is the patient's responsibility. This arrangement is part of your contract with your insurance company.
   a. **Basic treatment procedures** (cleanings, fillings, cores, post cores) will require full copay or payment in full on the day of service.
   b. **Restorative treatment procedures** (crowns, bridges, dentures, partials, occlusal guards, simple extractions, root canal therapy) will require a commitment payment of 50% down at your first appointment. Once treatment is completed, the remaining 50% is due immediately upon arrival. Any portions unpaid after insurance pays their portion will be your responsibility to pay within 30 days of the insurance payment (via mail, phone or in person).
   c. **Major treatment procedures** (oral surgery with sedation, Braces/Invisalign, Implants) will have separate financial payment policies.

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3. NON-COVERED SERVICES
   Please be aware that your insurance company may not cover some of the necessary services rendered. You will be responsible for these services according to the Basic, Restorative, and Major treatment procedure payment policies listed in policy 2 above.

   _____ INITIAL

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4. CLAIM SUBMISSION
   Your insurance benefit is a contract between you and your insurance company. As a courtesy to you, we will submit your claims for payment directly to us for services rendered. It is your responsibility to comply with any request for information that the insurance might need in order to pay the claim. Failure to do so will result in a transfer of the balance to you.

   _____ INITIAL

5. NON-PAYMENT
   If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay the balance in full. Partial payments will not be accepted unless negotiated. Please be aware that if a balance remains unpaid, your account will be referred to a collection agency.

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6. COVERAGE CHANGES
   If your insurance coverage changes, you must notify us before your next appointment so that we can make the appropriate changes to help you maximize your benefits. As a courtesy to you, we will submit your claims to your new insurance provider for payment directly to us for services rendered.

   _____ INITIAL

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. I acknowledge that I have read and accepted the financial/payment policy of Fortson Dentistry and that all of my questions have been answered to my satisfaction.

_____ _____

Patient or Guardian Signature Date

_____ _____

Fortson Dentistry Signature Date