Financial Policy

At Sarasota Center for General Dentistry (SCGD), we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Below is our financial policy for all our patients. **Please read and initial each item and sign at the bottom of the page.**

Initial* **if you do not have insurance please review the last three items.**

_____***** Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Please note that Dental Benefit plans will never pay for your dental care in full. It is only meant to assist you.**

_____* We will estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.** If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This will delay treatment but will give you a better out-of-pocket estimate.

_____* We will bill your insurance as a courtesy. If insurance does not pay within 45 days, **SCGD** reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____* In the event that your insurance company requests additional information regarding your claim, above and beyond the normal documentation, this additional information may require a fee.

_____* SCGD does require payment in full for your portion at the time of service. We accept MasterCard, Visa, Discover, cash and checks. If you are in need of an extended finance option, we also work with CareCredit. These companies offer 3, 6 or 12 months "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.

_____* A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least 48 hour** notice to avoid a **cancellation fee** (emergencies are an exception).

_____* In the event of an emergency after regular business hours, an **emergency fee** will be charged in addition to the necessary treatment fees.

I agree with the above conditions.

Print Name: _____ Date:_____

Patient/Parent Signature:

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