Rogers Family Dental
Robert C. Rogers DDS
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201 North State Street Orem,
UT 84057
(801)225-7712

Financial Policy and Agreement

Thank you for choosing us as your dental provider. We are committed to providing you with excellent patient care. The following is an explanation of our Financial Policy, which you must read and sign prior to any current and future dental evaluation or treatment in this office.

1. Each patient is responsible for his/her own account. **Patients who have no insurance are required to pay 100% of services at time of treatment.** If this not possible, you will need to make payment arrangements with our office prior to any dental evaluation or treatment. We accept cash, personal check, VISA, Master Card, American Express, Discover, and Care Credit.
2. **Your dental insurance policy is a contract between you and your insurance carrier.** We are not a part of the insurance contract. As a courtesy we will bill up to two insurance companies. **It is the patient's responsibility to provide current and correct information and to follow-up on any unpaid claims.** In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding non-payment of you insurance claims(s).
3. You are responsible for knowing what procedures and providers are covered by your dental plan. Any service provided, but not covered by your insurance company will be your responsibility.
4. **All insurance information needs to be updated on day of dental service. We cannot back bill another insurance company. If your insurance company has not paid your full account balance with 90 days, you must pay the outstanding balance without further delay.**
5. Payments on accounts billed are expected with 30 days. Delinquent accounts will be charge interest at 1.5% per month.
6. The undersigned specifically agrees to pay all attorneys' fees and court costs in the event that legal action is taken to collect on an account. The undersigned further agrees to pay an additional amount representing up to 40% of the principle balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.
7. I hereby consent to receiving manually, dialed and/or auto-dialed calls and/or text/SMS messages (which may include artificial or pre-recorded collection and/or healthcare related messages) to my wireless/cellular number and any other telephone number(s) provided or obtained during any interaction, agreement, or communication with **Rogers Family Dental** and/or its affiliates, agents, contractors and assignees, including but not limited to any account management/billing company(ies) and/or third-party collection agency(ies) and their respective agents.
8. **Patients who fail to appear for their scheduled appointments *may be charged* a $25 missed appointment fee, unless the patient contacts the office and cancels the appointment at least 48 hours prior to their appointment.**

Usual and Customary Fees

Our fees for dental services reflect the usual and customary fees in the community. You are responsible for payment regardless of any dental insurance company's determination of usual and customary fees for dental services. If our office is a preferred provider with your insurance company, we will abide by their usual and customary rates. However, you will still be responsible for your portion of the bill that they do not pay and for services that are not covered on your policy.

Authorization to Release Information

I hereby authorize this office to release information concerning my dental treatment to my insurance carriers.

Authorization to Pay Benefits

I further authorize and direct said agency, attorney or insurance company to pay from the proceeds of benefits of any recovery or insurance payments in my care, directly to the providers of this office for their professional services rendered. I understand that this in no way relieves me of my personal responsibility for paying my provider when treatment is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

Signature of Responsible Party _____ **Date:** _____ 1/2020