Mosaic Dentistry Financial Policy

We are pleased that you have chosen Mosaic Dentistry for your dental needs. In order to better inform you, please read the following summary of our financial policy.

Insurance

You, as the patient, are responsible for all charges regardless of insurance limitations. As a courtesy, our office is happy to file claims with your **primary** insurance company for services rendered. Your deductible, co-payment, and/or co-insurance are due at the time of service. However, if we have not received payment from your insurance company within 30-days from the date of service, you will be expected to pay the balance in full. If you have **secondary** insurance coverage, we will be happy to file for you and have the insurance company pay to you directly. We will not be able to estimate or accept assignment from the secondary insurance company.

Payment

We realize that patients have financial needs and we will do our best to find a solution that will work best for you. Our office accepts Visa, MasterCard, Discover, American Express, and personal checks with proper identification. Returned checks may be recovered electronically along with state allowed recovery fee. Payment of co-insurance, deductible, and/or co-payment is required at the time services are rendered unless other arrangements have been made in advance. Some appointments may require a portion of the estimated patient responsibility to be paid at the time of scheduling.

Missed Appointments/ Late cancellations

Your appointment is reserved especially for you with your assigned provider. Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time reserved for you. Please call our office and speak to an appointment coordinator **3 business prior to your appointment** if you must reschedule. Unfortunately, if the required notice is not given, future appointments may be subject to a deposit in order to reserve the time. This deposit may be applied towards treatment or held on your account for future appointments. Excessive abuse of this policy may result in discharge from the practice.

I have read and understand the above written financial policy. I agree to assign insurance benefits to Mosaic Dentistry. I also agree that should it become necessary to forward my account for collection proceedings, in addition to the amount owed, I will also be responsible for the fees associated with the costs of collection which will represent 30% of the balance.

_____ _____ _____

Signature Date Relationship if signed by Patient's Representative

I designate _____ as a person with whom Mosaic Dentistry can speak about my charges, billing, treatment appointments and all aspects pertaining to my association with Mosaic Dentistry.

_____ _____

Signature Date