Financial Policy

Please read the following and sign below.

Your health, comfort and satisfaction are the primary concerns of Dr. Leavitt and his team. Please inform us of any conditions which may require special attention, so we can ensure that your visits with us are pleasant experiences. An estimate of the cost of your treatment will be provided. Our office will estimate your insurance payment, but we can never guarantee what an insurance carrier will pay. Your portion will be collected on or before treatment is started. We accept for payment all major credit cards, cash, or checks. CareCredit is accepted as an extended payment option. For treatment over $500 we offer 5% discount when treatment is prepaid with cash or check.

We are happy to help file your insurance to receive your dental benefits. Our office will do all we can to facilitate claim payment, but we do not have the power to make your plan pay. Deductibles and co-payments are typically built into most plans and are due on the day of your service as regulated by State Law. If you have any questions regarding your dental plan, we will try to answer them to the best of our knowledge. However, your Employee Benefits Director is your best resource to help you become familiar with your specific plan and its restrictions.

Statements for outstanding balances are mailed at the end of each month and payments are due within 10 days. Balances past 60 days for any reason will be charged an interest rate of 1.5% per month. Accounts past 90 days will be considered delinquent and will be turned over to collections.

I, _____, recognize and accept personal responsibility for the payment of professional fees, regardless of any dental benefit I have which may apply. I understand that an estimate for services will be provided and I am required to pay my estimated portion at the time the service will be performed. I understand that I am responsible for any balance left after my insurance company has paid their portion of my bill.

I authorize Dr. Leavitt to release my dental/medical histories and other information regarding my dental treatment to third party payors and/or other health professionals as necessary.

_____

Patient (please print)

_____ _____

Patient or Guardian Signature Date