CURTIS H. ROY
AND ASSOCIATES, LLC
GENERAL DENTISTRY
and
SPECIALTY PRACTICE

OFFICE POLICIES AND FINANCIAL AGREEMENT

It is our desire to make high quality dental care affordable to everyone. The established financial policy of this office is that full payment is due at the time of service...however, we accept assignment of benefits on most major insurance policies, and also have charge plans available should you need to make extended payments on your account. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require that you read, agree to, and sign before any treatment.

All new patients must complete our "Patient Information Sheet" and Patient History Sheet" before seeing the doctor.

PATIENTS WITHOUT INSURANCE

If you do not have insurance you may pay at the time of service, or you may use one of our extended payment plans, once your application has been approved. Payment for visits must be received in full at the time of service to allow us time to process an application, if necessary.

PAYMENT OPTIONS

-CASH, CHECK
-MASTERCARD, VISA, DISCOVER, or AMERICAN EXPRESS
-EXTENDED PAYMENT PLANS

We are pleased to offer extended payment plans and 12-month interest free financing. This allows our patients to make monthly payments, instead of having to pay in full at the time of service. If you would like to make extended payments for services provided at our office, simply fill out an application form to establish your line of credit. There is NO CHARGE for completing the application and there is NO ANNUAL FEE. We encourage everyone to establish charge privileges. If at any time in the future you, or other family members, wish to take advantage of the charge plans your credit is already established.

PLEASE CIRCLE ONE OF THE FOLLOWING PAYMENT OPTIONS

With Insurance:

1. I prefer to pay on each visit and be reimbursed by my insurance carrier.
2. I prefer for you to file my insurance and I am responsible for any portion they do not pay for.
3. I prefer for you to file my insurance and open a charge account through one of your extended payment plans.

Without Insurance:

1. I prefer to pay office in full upon each visit.
2. I prefer to open a charge account through one of your extended payment plans.

PLEASE READ CAREFULLY

MINORS

The adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied, unless charges have been pre-authorized from the parent or legal guardian, to listed credit cards, extended payment options, or payment by cash or check at the time of service.

CANCELLATION POLICY

When you are scheduled to see the Doctor or the Hygienist, we require a 24-Hour Notice of Appointment Cancellation. If you have a confirmed appointment and fail to cancel, you will be billed $25.00 for that reserved appointment time.

DEPOSIT

A deposit totaling 30% will be due at the time of scheduling an appointment for dental treatment. This deposit will be forfeited if the patient does not give Dr. Curtis Roy and Associates a 24-hour notice of cancellation or is a no show appointment. If the deposit is forfeited, it becomes the property of Dr. Curtis Roy and Associates.

REGARDING INSURANCE

This office will file insurance for dental procedures upon receipt of necessary insurance information. This is a service that we provide, but please remember that you have the contract with your insurance company and are ultimately responsible for payment. We cannot accept responsibility for collecting from your insurance company nor negotiating a settlement on the disputed claim. However, our insurance coordinator is available if you need assistance.

Remember, you are the holder of the contract. It is your responsibility to make sure you understand the contract between you and your insurance company, and you know your benefits for the policy. This is not our responsibility. After 30 days, if your insurance company has not rendered payment, your account will be delinquent and considered for collections. If this should happen we will no longer file your dental insurance for you or any of your families future dental visits.

REGARDING DISCOUNTED DENTAL PLANS

We accept several discounted plans. You must provide us with the correct information or card at the time of the visit, so we may verify your coverage. If, for some reason, you find out after your appointment that you are on a discounted dental plan and you have already accepted treatment and have paid in full, **we will not go back and reimburse you for work already completed.**

UCR (USUAL AND CUSTOMARY RATES)

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payment in full, regardless of an insurance company's arbitrary determination of usual and customary rates.

PAST DUE ACCOUNTS

Open accounts with no acceptable payment activity for 60 days will be considered past due. A billing charge may be assessed to the account balance, along with a finance charge of 12% per balance along with these additional charges.

COLLECTIONS

Open accounts with no acceptable payment activity for 90 days will be automatically placed with our collection agency. You will be responsible for the original past due balance, along with these additional charges.

MANAGED CARE PLANS

We are members of several managed care plans and we are obligated to follow their guidelines, but you are the holder of the contract. It is your responsibility to make sure that we are on your provider list. If work is performed and we are not on your policy, you will be responsible for our regular fees.

INSURANCE SIGNATURE AUTHORIZATION I authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim submitted for myself and/or dependents. This signature will bind me as though I had personally signed each claim.

AUTHORITY TO TREAT

I give Dr. Curtis Roy and Associates the authority to administer dental x-rays, local injections, anesthetics, and if requested, nitrous oxide or a tranquilizer in the subsequent treatment of my case. If I have a medical condition, such as a heart murmur that requires pre-medications, I acknowledge that it is my responsibility to inform remind the Doctor, Assistant, or the Hygienist.

PHOTOGRAPHS

I give my permission to Dr. Curtis Roy or any representative he may designate, to photograph me for diagnostic purpose and to enhance the medical record. I agree that these photographs will remain Dr. Roy's property (this includes all diagnostic x-rays). I further authorize Dr. Roy to use these photographs for teaching purposes, to illustrate scientific papers, books, for use in general lectures, and for promotion of the offices. It is especially understood that in any publication or use, I shall not be identified by name.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I have read, understand, and agree to the above Financial Policy.

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PATIENT'S SIGNATURE (PARENT IF MINOR) **DATE**