



FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy.

Our office is happy to cooperate with patients who are covered by dental insurance. You should carefully read your policy to be sure that you are fully aware of any restrictions that apply to the benefits provided. Our computer has the capability to estimate what your co-pay will be. This co-pay is due at the time of treatment. For example, if your plan has a \$50 deductible, you would be asked to pay this at the time of service. Dental Insurance is a contract between the patient and the insurance company. Some treatment provided may be "non-covered" services dependent on the type of insurance coverage you have. The practice will complete all forms pertaining to your claim and send them promptly to your insurance company. However, if payment is not received within forty-five (45) days, it will be your responsibility to promptly pay any remaining balance. There will be a finance charge for any unpaid balances over ninety (90) days.

Certain types of insurance (or, for some insurance, our office has elected) require payment in full at the time services is provided. IF YOUR INSURANCE COMPANY REQUIRES YOU TO PRE-SELECT A PROVIDER, PLEASE CHECK WITH OUR STAFF FOR CO-PAYMENT PRIOR TO TREATMENT BEGINNING. THERE WILL BE A MISSED APPOINTMENT FEE FOR APPOINTMENTS CANCELLED WITH LESS THAN TWENTY-FOUR (24) HOURS NOTICE.

AUTHORIZATION:

I hereby authorized payment directly to Thomas J. Hoover DDS & Associates of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorized Thomas J. Hoover D.D.S. & Associates to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Minor Patients

The adult accompanying a minor and the parents (or guardians) are responsible for full payment.

Please let us know if you have any questions or concerns.

I have read the Financial Policy above. I understand and agree to the Financial Policy.

Signature of Patient or Responsible Party

Date