Brett H. Loeser, DDS, FAGD, FICOI

Our Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require that you read, and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS.

WE ACCEPT CARE CREDIT. (Please see Peggy if you would like to use this option.)

WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Regarding Insurance

We will accept assignment of insurance benefits. However, we do require that you pay your co-payment of the bill at the time of service. The balance is your responsibility whether your insurance pays it or not. We cannot bill your insurance company unless you provide us with your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits we require that you be pre-approved on our extended payment plan or provide a credit card with authorization to bill that account balance. If your insurance company has not paid your account in full within 45 days, the balance will automatically be transferred to your credit card or the extended payment plan. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary by your insurance company.

Regarding insurance plans where we are a participating provider. All co-pays and deductibles are due at the time of treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

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Usual and Customary Rates

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

Adult Patients

Adult patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been preauthorized to an approved credit plan, credit card or payment by cash or check at the time of the service has been verified.

Missed Appointments

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Financial Responsibility

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney fees and costs of collection in the event of default. I further understand that if a payment becomes **30** days past due, delinquency at the lesser of the annual rate of **18%**, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due. Thank you for understanding our Financial Policy.

Please let us know if you have any questions or concerns

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

X_____ Date_____
Signature of Patient or Responsible Party

X_____ Date_____
Signature of Co-Responsible Party

X_____ Date_____
Signature Of Office Manager