Office & Financial Agreement

Thank you for choosing Dr. Jennifer Kluth for your dentistry. Our mission is to provide the utmost in personalized, high quality, compassionate dental care to every patient every day. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. The following is a statement of our Office Policies and Financial Agreement. We ask that you please read, agree to and sign the agreement before any treatment is rendered.

REGARDING INSURANCE

For decades dental insurance has been an integral part of oral health planning; however, in the past few years it has become more difficult for the dental practice to deal with insurance companies. We are a third party to the contract and the insurance companies are not obligated to share your confidential policy information with us or required to send payment to us.

There are constant changes being made by your employer and insurance carriers to your coverage, deductibles and annual maximum. These changes are not being shared with us. Therefore, it is impossible for us to know exactly what your policy covers.

In order for us to maintain our high level of service to you the patient, we provide the courtesy of submitting the claim on your behalf and supporting you with maximizing your benefits. However, we are unable to carry your insurance balance for longer than 60 days. Policy coverage, changes and follow-up on unpaid claims is your responsibility. Please be prepared to show your insurance card at the time of your visit. **_____(Initial)**

PAYMENT OPTIONS

Your options include Cash, Check, MasterCard, Visa, Discover and American Express. We are pleased to offer you a choice of No Interest or Extended Payment Plans to qualified applicants through CareCredit, our financial partner. If you would like to make extended payments for services provided at our office, please ask Debbie for assistance in filling out an application form. **_____(Initial)**

ADDITIONAL CHARGES

A fee of $25.00 will be charged on all returned checks.**_____(Initial)**

DELINQUENT ACCOUNTS

After 90 days, all accounts that are not paid in full may be sent to a third party collection agency. Any accounts turned over to collections will be assessed a collection fee of 50%. **_____(Initial)**

CANCELLATION POLICY

If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of two-business days notice. All changes in your scheduled appointment must be handled during our regular business hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist. **____(Initial)**

OFFICE HOURS:

Monday	8:30 AM – 5:30 PM
Wednesday	8:30 AM – 5:30 PM
Friday	8:30 AM – 5:30 PM

I have read, understand and agree to the above Office Policies and Financial Agreement.

_____ _____

PATIENT SIGNATURE **DATE**
(PARENT/GUARANTOR signature if Patient is a MINOR)

_____

CHILD'S NAME