BISON DENTISTRY
360 Greenhaven Terrace,
Tonawanda, NY 14150, USA
716-696-1951

Office Financial Policy

FINANCIAL POLICY

Bison Dentistry thanks you for choosing our office for your Dental needs. Our expert team of Dentists, Hygienists, Dental Assistants and Business coordinators look forward to serving you. We have identified that a clear understanding of your dental needs and the financial responsibility for your care are very important. Our policy is to provide each patient with a written estimate of recommended treatment. Our business staff will provide you with estimated costs of your treatment; however, we encourage all patients to familiarize themselves with their insurance plan/policies.

OFFICE AND FINANCIAL POLICIES

1. Bison Dentistry expects that all patient co-payments are due at the time services are rendered. We do offer outside financing for extensive treatment. Financing is subject to approval by a participating financial group. For your convenience, we accept cash, Personal Checks, Visa, MasterCard, Amex, Care credit and debit Cards.
2. All patients having an existing account balance that are past due will not be rendered any service until balance has been cleared or unless arrangements are made prior to the treatment. All future treatment and DELIVERIES will be placed on hold until balance is paid in full.
3. Patient balances that go unpaid for 90 days or more will be subject to the following additional charges: Interest charges (1% per month or 20% APR) Collection fees (up to 42% of the full balance) and/or legal charges. If payment is delinquent, the patient will be responsible for payment of collection, attorney fees, and court costs associated with the recovery of the monies due on the account
4. Major services require a deposit of at least half the estimated patient portion at the time the appointment is made.
5. If a patient decides to make a financial arrangement with Bison Dentistry, a card on file is required to process payments.
6. Payment arrangement made with Bison Dentistry: If for any reason the Debtor should not oblige to any section or portion of this Agreement, the Debtor shall be considered in default. Under such an event, the remaining balance of the Amount Owed shall be due within five (5) business days with the Debtor liable to pay all reasonable attorney's fees and costs of collection of the Creditor.
7. Bison Dentistry reserves the right to charge $35.00 for all returned checks.
8. Any patient, who defaults on a payment arrangement by 10 days beyond the contractual agreement, is expected to pay the balance in full immediately.
9. Appointments not canceled with 24 hour notice, will result in a charge of $45.00 for time reserved.
10. Bison Dentistry does not extend any courtesy discounts to anyone unless agreed on a case to case basis.
11. All patients under the age of 18 should be accompanied by a parent or a guardian, who must remain in the office premises until the procedure is complete.
12. All insurance downgrades, if any, are patient responsibility.

INSURANCE POLICIES

1. Insurance balances are ultimately the patient's obligation. We file (most) insurances at no cost to you as a courtesy. We are glad to offer this service. However, insurance balances that are not paid after 60 days may be billed directly to you.

2. It is the patient's responsibility to follow up with their insurance company for denied services.
3. It is your responsibility to be familiar with restrictions, limitations, exclusions and deductions that may apply to your plan.
4. All deductibles and co-payments must be satisfied at the time treatment is rendered. The requested amount of co-payment is estimated on the information received from your insurance company. All claims that are adjusted by the insurance company will become your additional responsibility and payable to Bison Dentistry immediately.
5. Patients who have insurance companies, of which Bison Dentistry is not a participant, will be expected to pay in full amount of treatment at time of service. We will provide you with a statement of service to submit to your insurance carrier once the balance is paid in full.

Patient First Name

Patient Last Name

Patient Birth Date

☐ I have received this policy and agree with its contents.

Signature

Signature By Patient

Date signed:

Patient's Signature

By drawing in the box above I understand and agree that this is a legal representation of my signature

Signature By Guardian

Name

Relationship

Address

Date signed:

Legal Guardian's Signature

By drawing in the box above I understand and agree that this is a legal representation of my signature