funke
family dentistry

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WRITTEN FINANCIAL POLICY

Our primary mission is to deliver the best and most comprehensive dental care available, while making the cost of optimal care as easy and manageable for our patients as possible. Our goal is to assist you in any way possible to allow you to receive the superior dentistry you deserve.

Insurance

As a courtesy to our patients we gladly process your insurance claim. We ESTIMATE your deductible for the year and your portion due that is not covered by insurance. The total portion that is not covered by insurance is due at the time of you service. Patients without dental insurance are required to pay in full on the date services are rendered. For your convenience, please note our payment options. Please initial _____

Missed Appointments/Cancelations

A 24-hour notice is required for cancellation of appointments. We reserve the right to charge a fee for broken appointments or ones that are not cancelled beforehand within a reasonable time frame. Please Initial_____

Payment Options

1. Cash
2. Personal Check
3. Visa or MasterCard (online payments available)
4. Care Credit: offers patients a line of credit to cover you or your family's dental care needs. In most situations this is an interest free program for up to a year. Inquire with office staff to attain further information regarding the different programs they offer.
5. As a thank you to our new and existing patients we have a referral program. When you refer a friend or family member to our office, you and the new patient will receive a $50 credit to your account when the new patient comes in for their first appointment

* Please feel free to ask further questions about payment options*

Administrative Fees

1. You are personally responsible for payment concerning any and all dental services rendered by Funke Family Dentistry, S.C.
2. A service fee of $50 is charged for any returned check.
3. A late payment fee of 1% of the total account balance will be charged monthly on unpaid balances that are 60-days past due.
4. If your balance has not been paid-in-full within 90-days after treatment, your account will be surrendered to a collection agency.

I hereby assign to Funke Family Dentistry any and all payments and any and all right to receive payments for dental services rendered by my dependents or myself. I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor. I accept full responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges and hereby authorize the use of my signature on all insurance submissions.

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Patient, Parent or Guardian Signature Date

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Patient Name (Please Print)

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