FINANCIAL POLICY

Hartley Family Dentistry
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410 E. Washington St.
PO Box 379
Slinger, WI 53086

This is an agreement between Hartley Family Dentistry as creditor, and the Patient/Debtor named on this form.

In this agreement, the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to Hartley Family Dentistry.

By executing this agreement, you are agreeing to pay for all services that are received.

Account Statement: If you have a balance on your account, we will send you a statement every 21 days. It will show separately the previous balance, any new charges to the account, the finance charges, if any, and any payments or credits applied to your account during the statement period. Unless, we approve other arrangements, the balance of your statement is due and payable when the statement is issued, and is past due if not paid within 10 days of statement date.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Changing Accounts: Patients cannot be moved from an existing account if the account balance is not zero ($0).

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company will pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. Each insurance company may have unique and different requirements relating to referrals and pre-authorizations. Although we will assist you, it is ultimately your responsibility to make sure that the necessary authorizations have been received prior to treatment. Failure to obtain the referral and/or pre-authorization may result in a lower payment from the insurance company.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection of the balance to an attorney, you agree to pay all attorney's fees that we incur plus all court costs.

Payment options if you have insurance:

A. You choose to pay your deduction and any out-of-pocket portions at the time services are rendered by cash, check, debit or credit card.
B. You choose to pay for services rendered by cash, check, debit or credit card. We will request your insurance carrier send their payment directly to you.
C. In the case of extensive treatment (crowns, bridges, etc.) we require 50% of your out-of-pocket portion on the start or preparation date, and the balance on the completion or delivery date unless other arrangements have been made.

Payment options if you have no insurance:

A. Our office requires that payment be made on the date services are rendered. A 5% discount will be extended for payment made in full with cash or check. A 3% discount will be extended for payment made in full with your Credit/Debit/ FSA or HAS card.
B. On treatment including laboratory fees (crowns, bridges, dentures, etc) we require 50% down at the initial appointment and the balance on the completion or delivery date, unless other arrangements have been made.
C. In the case of extensive treatment, our office does accept Care Credit. Please see our business office for more details prior to the start of treatment.
D. Payment plan options are available. Please see our business office for details.

Missed Appointment Fee: Our office reserves the right to assess a missed appointment fee to your account if you do not show up for an appointment, or cancel with less than 24 hours notice. This fee must be paid before a new appointment is scheduled.

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Finance Charge: A finance charge will be imposed on each item on your account that has not been paid within ninety (90) days of the time the item was added to the account. The Finance Charge will be computed at the rate of one percent (1%) per month or an Annual Percentage Rate of twelve percent (12%). The Finance Charge on your account is computed by applying the periodic rate (1%) to the “overdue balance” of your account. Taking the balance owed ninety (90) days ago, and then subtracting any payments or credits applied to the account during that time calculate the “overdue balance” of your account.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent’s responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or worker’s compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient’s responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

I, ______________________________ have read and understand the financial policies of Harley Family Dentistry. I hereby agree to these policies as written.

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Patient / Responsible Party Date