Piedmont Family Dentistry
181 W. WILKES MEDICAL CENTER RD.
FERGUSON, NC 28624
336-973-5060

FINANCIAL POLICY

Payment for services is due at the time of treatment by one or more of the following:

- Dental Insurance (We accept and file most dental insurances, but we are only an in-network provider for Delta Dental insurance).
- Cash, debit/credit card or check
- CareCredit (a monthly payment plan which requires prior credit approval through an independent company)

Insurance: Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract. We will verify and file your PRIMARY insurance, as a courtesy to you.

NOTE: ALTHOUGH WE MAY ESTIMATE WHAT YOUR INSURANCE MAY PAY, IT IS THE INSURANCE COMPANY THAT MAKES THE FINAL DETERMINATION OF YOUR ELIGIBILITY. WE DO **NOT** GUARANTEE THE ACCURACT OF ANY ESTIMATE OF BENEFITS RELATING TO THE PATIENT'S PLANNED OR RENDERED TREATMENT. YOU ARE RESPONSIBLE FOR PAYMENT OF ANY PORTION OF THE CHARGES WHICH ARE NOT COVERED BY YOUR INSURANCE. Benefits are payable in accordance with the coverage in effect at the time treatment is actually rendered and are subject to plan maximums, deductibles, co-insurance factors and any other specific plan limitations. It is your full responsibility to understand the terms and conditions of your coverage. You are responsible for paying any deductibles and co-payments at the time treatment is rendered.

We will gladly file your Medicaid, North Carolina Health Choice or your dental insurance at this office. In order to do so, you must be able to present your current insurance card. If you have a co-payment or out of pocket expense, you are required to pay this that the time of service.

Returned Checks: You will be charged a fee (currently $30 plus the bank's fee) for any checks returned to us by your bank. After a returned check, only cash or credit card payments will then be accepting for future services or remaining account balance.

Monthly Statements: If you have a balance on your account for any reason, we will send you a monthly statement. Unless other arrangements are agreed to by us, the balance on your statement is due and payable by the indicated due date and will be considered past due if not paid by such date.

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 may also be assessed a collection fee.

Cancellation Policy: 24-hour notice is required for any cancellations. If you fail to provide a 24-hour notice or you do not show for your scheduled appointment, you will not longer be able to schedule future appointments.

PATIENT NAME: ___________________________________

SIGNATURE: _______________________________________ DATE:______/______/______
(Parent/Guardian if patient is a minor)