PT NAME: _____

SCHROEDER AND SCHROEDER DENTISTRY: Financial Policy- UPDATED 9/2025

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts: cash, personal checks, credit cards (3.95% processing fee applies) we offer four (4) outside financing options: Care Credit, Sunbit, Alphean and Cherry, we will be happy to discuss these options with you.

**Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges up to 35%.

Do You Have Insurance?

• We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.

Employer name: _____

Employer address: _____

• As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide insurance **estimate** to you, however**, it is not a guarantee that your insurance will pay exactly as estimated**. Your insurance company and your plan benefits will determine the actual amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. After 60 days, if payment is not received or your claim is denied, you will be responsible for paying the unpaid balance.
****Unpaid balances sent to collections will incur ALL collection and legal fees. An interest rate of up to 2% may be charged on all delinquent balances****.

• We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

• We ask that you pay the deductible and/or co-payment, which is the estimated amount, not covered by your insurance company, prior to scheduling any treatment.

• We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

Consent:
I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable prior to time services are rendered unless financial arrangements have been made.
I further understand that a finance charge (up to 2%), collection charge and/or attorney fee will be added to any balance over 90 days overdue. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose.

_____ NAME (SIGNATURE)

_____ DATE