Amy D. Russell, DMD

Financial Policies & Agreement

Patient Name: _____ Date of Birth: _____

Please check one of the following:

___ I have presented evidence of valid insurance coverage, as of this date below to the office of Dr. Amy Russell.

___ Self-pay. I understand I am financially responsible for all charges incurred for services provided. I understand that payment is due at the time of service.

Basic Policy: Payment is due in full at the time of service.

For patients with insurance: We Will bill most PPO insurance carriers as a courtesy to you if proper paperwork is proved to us. Copayments and deductibles are due at the time of service. Your agreement with your insurance carrier is private; Therefore, we **DO NOT** routinely research why an insurance carrier has not paid or why it paid less than anticipated for services provided. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

Non-Covered Services: Any Procedure **NOT** paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance denial.

Missed Appointment: Dr. Amy Russell requests a 24 – Hour notice upon canceling any appointment. If prior notice is **NOT** given you will be charged a $50 missed appointment fee. We value your business and ask that you respect our office scheduling policies.

I have read, understand, and agree to the above financial policy for payment for dental services rendered. The patient is ultimately responsible for all fees and services.

Signature: _____ **Date:** _____

PATIENTS WITH INSURANCE: I hereby assign all dental benefits to Amy D. Russell, DMD. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance. I also authorize the release of information necessary to secure the payment from my dental insurance company.

Signature: _____ **Date:** _____