FINANCIAL POLICY

ARIVE
FAMILY DENTAL
CRAIG ARIVE
D.D.S.

OWN YOUR SMILE

4019 Columbus Ave., Ste D
Anderson, IN 46013

Area Code: 765

Phone: 642•3100
Fax: 642•7222

Internet:
www.arivefamilydental.com
Email:
info@arivedental.com

Thank you for choosing Arive Family Dental. We are committed to providing you with the highest quality dental care, so you may attain optimum oral health. Please understand that payment is considered part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to, and sign prior to treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and Care Credit. For your convenience, we also offer automatic payments to your credit card as a form of payment. Please let us know if you would like to use this method of payment, as there is an additional authorization form to sign.

Please note: Returned checks will be subject to additional fees. In 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 incurred, along with any charges associated with those agencies, and/or finance charges

Insurance:

As a courtesy, we will help by processing your insurance claims. Please understand that we will provide an insurance estimate; however, it is not a guarantee of what your insurance will pay. Your insurance company and plan benefits determine the amount paid. We will do all we can to make sure your estimate is as accurate as possible. You must inform Arive Family Dental of benefits used and or pending at any other clinic(s) to determine if your benefit limits are exceeded. Fees resulting from accepted treatment that is not covered or non-reimbursable is the responsibility of the patient. Arive Family dental strives to set fees that are usual and customary for the Anderson area.

In Network. If Arive Family Dental is a participating provider in your network, your insurer may dictate your financial responsibility for treatment. For example, deductibles and co-payments are the responsibility of the patient.

Out of Network. We emphasize that as your dental care provider, our relationship is with you - not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party of that contract.

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 payments directly to our office.

Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurer does not make payment within 30 days, we will ask that you contact the insurance company to make sure payment is expected soon. If payment by your insurance company is not received within 60 days, or your claim is denied, you will be responsible for paying the full amount at that time.

We will cooperate fully with the regulations and requests of your insurance company which would assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors with Separated or Divorced Parents:

When two parents are each responsible for one half of the cost of a child's dental care, the Parent or Gaurdian who brings the child is responsible for the co-insurance or the full fee.

Initials: *Date:*

X _____

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.

Signature of patient or legal gaurdian: *Date:*

X _____

Printed Name:

X _____