Nick J. McHargue, D.D.S., P.C.
3301 Broadway Business Park Court Suite C - Columbia, MO 65203 - (573) 445-3630

FINANCIAL POLICY

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 expected when services are rendered, unless other arrangements are made in advance.*** Our office accepts cash, personal checks, American Express, Discover, MasterCard, and Visa. Outside financing is available through Care Credit upon approval.

If you have dental insurance:

- As a courtesy to you, we may help you process your insurance claims. *Please understand that we will provide an 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 ultimately determine the amount paid. We will do all we can to make sure your estimate is as accurate as possible.
- *All charges you incur are your responsibility, regardless of your insurance coverage.* 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. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge competitive rates for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you pay the deductible and estimated copayment at the time we provide service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, you will be asked to pay the balance and seek reimbursement from your insurance company.
- Any overpayment your insurance has paid will remain on your account to apply toward future services, unless you request a refund.

Patient Balances:

- Any balances incurred by the patient that are not paid after 30 days from the date of service (OR if the patient has insurance, balances that are not paid after 30 days from the statement issue date), will be charged a late fee of 1.5% monthly (18% annual).
- Any unpaid balance over 90 days from the date of service will be considered delinquent and turned over to a collection agency. 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 30%.
- Returned checks are subject to a $35 processing charge.

Appointment guidelines:

- We require 24 hours notice if any change in your appointed time must be made. We do not double book patients, we respect your time so please respect ours. Patients who fail to give adequate notice or miss an appointment more than 1 time in a calendar year, will be charged a fee of $35. Any previous balances on a patient's account must be paid before any future treatment is performed.
- For appointments schedule for 1.5 hours or more, a $50 deposit is required to secure your initial treatment appointment. This is non-refundable should the patient not meet adequate guidelines mentioned above.
- In the event of an emergency after regular business hours a $100 emergency fee will be charged in addition to the necessary treatment fees.
- Arriving late (greater than 15 mins.) to an appointment may necessitate re-appointment.
- If you establish a history of cancellations or no show appointments, you may lose the privilege of being a patient at our office.

FINANCIAL AGREEMENT: I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that I am financially responsible for myself, or my dependents, for any charges regardless of insurance coverage and that payment is due at the time of service unless financial arrangements have been made in advance. Should I default, I agree to pay all costs of collections including interest applied, court costs, and /or attorney fees.

Responsible Party *PRINTED NAME* (for patients 17 yrs, or younger, parent or guardian MUST sign) ______________ Date

Enter your name and date, then SUBMIT. A printed copy will be waiting for you at your appointment to sign.

Responsible Party *SIGNATURE* (for patients 17 yrs, or younger, parent or guardian MUST sign)