Financial Policy

San Antonio ENDODONTICS

IF WE ONLY PROVIDE AN ENDODONTIC EVALUATION (LIMITED EVALUATION OR CONSULATION): This consists of an examination and testing, discussing the likelihood of maintaining the tooth, and treatment options available to you. Payment is due at the time of service. Our office will bill your insurance and any insurance overpayments will be reimbursed to you. (Please see PATIENTS WITH DENTAL INSURANCE below.)

IF WE PROVIDE TREATMENT: A $50 deposit fee is collected for any scheduled treatment appointments. The fee will be refunded or credited to your account at the time of the scheduled treatment appointment. In the event that the appointment is rescheduled or cancelled at least 48 hours prior to the scheduled appointment time, the fee will be refunded or credited to your account.

PATIENTS WITHOUT DENTAL INSURANCE: Fifty percent of the treatment fee will be collected at the start of treatment and the remaining balance will be collected upon completion of treatment. If treatment is completed in a single visit, payment will be collected at the time of service unless prior arrangements have been made.

PATIENTS WITH DENTAL INSURANCE: Any estimated copayments, deductibles or services not covered by your insurance will be collected from you at the time of service. Your insurance policy is a contract between you and your insurance company. (Please refer to your insurance company for any detailed policy questions). Verification of insurance coverage does not guarantee claim payment and any remaining balance on your account is your responsibility. Any insurance overpayments will be refunded to you within 30 days of last claim payment on your account.

INSTRUCTIONS FOR PATIENTS WITH DUAL DENTAL INSURANCE: We will provide the claim form to file the secondary claim. Once you receive the Explanation of Benefits from your primary insurance mail it to your secondary insurance along with the provided claim form.

Please let us know if you have any questions.

Please read the statements below and sign at the bottom of the page:
I understand that as a courtesy, a claim will be filed with my insurance carrier with associated forms and reports. I authorize the release of any information necessary to process this insurance claim. I authorize the payment of the applicable insurance benefits payable to me be made directly to San Antonio Endodontics or their providers. I understand that payment must be made at the time services are rendered unless prior arrangements are made.

I understand that I am responsible for the entire balance on my account, I am responsible for any fees the insurance company does not cover. I am also responsible for the cost of collection, as applicable.
I understand that if San Antonio Endodontics has not received insurance claim payments within 60 days of the original filing (which may include up to two claim submissions). I will be responsible for paying the remaining balance on my account on the due date reflected on my statement. A $35 fee will also be charged for any returned checks.

I understand that cancelling or rescheduling my appointment without a 48 hour notice is subject to a $50 cancellation fee along with prepayment of copay to secure the future appointment time.

I understand and agree to the terms outlined in this financial policy.

Patient/parent/legal representative signature: _____ **Date:** ___/___/___