



Michael L. & Cammie L. Housh, DDS, PC

Housh Family Dentistry
605 E. Hospital Rd., Suite 1
El Dorado Springs, MO 64744
Phone: (417) 876-3124

FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

1. Payment is due at time of service.
2. If insurance is involved, co-payment and any deductible are to be paid at the time services are rendered.
3. We accept cash, check, MasterCard, VISA, and Discover.

Dental insurance should be regarded as dental assistance. It is designed to help pay some of the costs of dental treatment. Because there are so many dental insurance companies and programs it is nearly impossible for us to have complete knowledge about all of them, or your status with your particular company. We will do our best to help you maximize your benefits. Dental insurance is meant to be a partial aid to defray professional fees. It is not designed to pay all of the costs of dental treatment.

Insurance is a contract between you and your insurance company. We are typically not a party to this contract. If we are, we will inform you and handle the claim according to our agreement with the insurance company. We file insurance as a courtesy to our patients. We will not become involved in disputes between you and your insurance regarding deductibles, co-payments, covered charges, secondary insurance and other matters regarding reimbursement. The kind of benefits in your contract depends on what you or your employer has negotiated with the insurance carrier. Returned checks will receive a \$30.00 overdraft charge. A 1% finance charge per month will be added to all account balances outstanding beyond 30 days from the date of service.

At the time of your initial appointment, please bring your insurance booklet. Your portion of the fees can then be computed and paid at the completion of that appointment. If the insurance payment varies from the computed amount, an adjustment will be made.

If care is being rendered on a minor child, the parent or guardian who accompanies the child to the appointment is financially responsible for the account. We will not get involved in divorce disputes.

You are responsible for timely payment of your account.

Thank you for understanding our financial policy.
Please let us know if you have any questions or concerns.

I understand that I am responsible for all costs of dental treatment regardless of what my insurance carrier may or may not pay. This signature will also serve as signature on file for assignment of insurance benefits. In the event of any default regarding charges incurred, the debtor will be obligated to pay all collections costs &/or attorney fees incurred by Housh Family Dentistry in the collection of these charges. I also understand that there will be a fee charged to my account if I do not show up for my appointment without a 24 hour notice of cancellation. The fee charged will be based upon the length of the appointment.

Patient Name _____ Relationship to Patient _____

Signature _____

Witness _____