Chantry Dental Care

Financial Policy Agreement

I (Name)____________________________________enter into this agreement as outlined on (date:)________________with Dr. Jeffery C. Chantry DDS, his related affiliate corporations, associates, and other related entities etc. of Dr. Chantry. Thank you for choosing our office as your dental care provider. We are committed to you and seeing that your dental experience is both successful and enjoyable. Please consider that financial reimbursement to the practice for services provided is part of that mutual experience. The following agreement of our financial policy is intended to lay the foundation for mutual understanding leading to an overall positive experience with our office.

Options:

We offer several financing options for your convenience (upon approved credit). You agree, to allow us to seek pre-approval on your behalf for potential financing plans with our outside agencies so that these options may be presented to you. We do not offer in house financing plans but rely on outside financing companies for these options. **Payment for services are to be made or arranged before service can be provided.** We accept cash, money orders, most major credit cards, and may accept personal checks. We charge $ 35.00 for returned checks. We require credit card and banking information together with signed authorization forms to be kept on file as collateral when large insurance payments are relied upon. We do not offer in house payment plans but rely on outside financing companies for such options.

Dental Insurance and Billing:

As a courtesy, we will help you process your insurance claims. It is important to understand, that the agreement regarding your employee benefits is between you, your employer, and your insurance companies. **The obligation you have with our practice is to pay for the services received, regardless of the amount that may or may not be reimbursed by your insurance carriers.** Before treatment, we will provide you with an estimate of the anticipated charges, as well as expected benefits however, we are unable to guarantee any reimbursement from your insurance company. **We will not enter into a dispute with your carrier over nonpayment issues** however we will assist you with reimbursement.
It is understood that changes in treatment may be necessary at any time, you agreed to allow the doctor to make such changes to the procedures and fees during the course of treatment as necessary and acceptance of financial responsibility for these changes. The office will attempt to make you aware of any alterations as they arise. We allow 60 days for reimbursement from your insurance company, after-which your entire balance will be due upon request and may be automatically transferred to your credit card or your prearranged method of payment on file. Please be aware that some, and perhaps all, of the services provided may be non-covered services and or may not be considered reasonable, necessary, or appropriate by your insurance company. Oftentimes, insurance companies' guidelines reflect the lowest standard of care rather than the best interest of the patient. Services will be billed according to accepted Dental and or Medical procedure codes as recognized by the Insurance industries. For services provided that do not fall into one of these procedure codes, or if the management of your condition requires significantly more time than usual, you may be billed at the rate of $600 per hour calculated in 6 minute minimum intervals or segments. (our hourly rate).

Outstanding Balances and Dispute Resolution:

Open balances can create tension between patients and providers, therefor running balances are not permitted. **You accept full responsibility for prompt payment on any unpaid balances.** As a courtesy, we may send a statement concerning an outstanding balance. We charge 2% monthly (24% annually) against your account for outstanding balances. Collection proceedings may begin if accounts are neglected. You understand that treatment may be delayed or terminated until accounts becomes current, additionally , you accept responsibility for poor treatment result or complications resulting from such delays. You also accept the responsibility for all interests accrued, collection fees, and legal expenses etc. with regard to collection activities.
It is understood that the art of dentistry is not an exact science and outcomes may vary as well as opinions concerning modalities of treatment or determination of success and no guarantees of results can ever be made. In the event that a dispute or dissatisfaction arises from either the services/procedures or restorations provided, treatment outcomes, or financial disputes etc., all parties agree to work at resolution with the office directly. You also agreed to allow Dr. Chantry or his personnel the opportunity to correct any defective restoration or resolve any such dispute. Additionally, if you elect to have corrections made elsewhere, you accept financial responsibility for the procedures which they shall provide. If a problem continues after everyone's best efforts, you agreed to seek assistance from C.D.A. peer review committees for an independent mediation process, and agree to accept their remedies. Finally, you agree (if all else fails) to binding arbitration as a final and conclusive mechanism for resolution, additionally, you waive all rights or future rights to suit and or trial in the resolution process concerning any aspect of the patient experience. With any litigation both parties agree to rely upon expert witnesses in good standing with the California Dental Association following their published code of ethics. Additionally, both parties agree to have such witnesses volunteer their time and that experts shall not be paid for their testimony.
Should it become necessary to terminate the doctor patient relationship, all parties agree to not allow disparagement of one another in public forums such as the internet, with future providers, insurance carriers, outside agencies, with individuals or groups of people etc.; to keep all aspects of this doctor- patient relationship confidential and private. All parties reserve all rights and avenues necessary for injunctive relief of any disparagement or breach of this privacy agreement.

Missed Appointments and Severability:

Your dental appointment is a reservation with our practice. We will do everything possible to keep your reservation as appointed. Reservations that are cancelled or missed without giving at least 48 hours notice may be billed to your account at our normal hourly rate for the time reserved. Repeated abuses of missed appointments or lack of follow through on recommended treatments, may be interpreted as, and result in a termination of the doctor patient relationship. Additionally, you (the patient) accept the consequences of delaying appropriate dental care.
You (the patient) understand and accept the conditions as stated above, have had all questions answered, accept these policies, and have been given a copy of this agreement. Additionally, if any portion of this agreement is found to be unenforceable or contrary to universal or local code etc., you agree that the remaining terms shall remain in force and therefor binding.

____________________________ ____________ ____________________________

Signature Date Witness/Practice Representative