PRAIRIE DENTAL GROUP
Bryan C. Bumpas D.D.S.

Financial Policy

We are committed to providing you the best possible care. If you have dental insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

We will be happy to process your claim for reimbursement. If we accept assignment of your insurance plan, you will only be required to pay an **estimated co-pay and deductible** or percentage as stated by your insurance company. Payment for these **estimated charges** is expected on your date of service and is payable by Visa, MasterCard, Discover, check or cash.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however that:

1. Your insurance is a contract between you, your employer and the insurance company and we are not a party of that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We will have no way of knowing how your insurance policy is written. All are different.
3. We cannot become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "Usual & Customary" charges etc., other than to supply factual information as necessary.

We must emphasize that as a dental provider, our relationship is with you, the patient and not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. I understand that if my insurance company fails to pay within 60 days of the claim being submitted, the full amount due is my responsibility and I will make payment in full.

A finance charge of $30.00 will be applied to all unpaid previous month's balance(s) on all accounts that are thirty (30) days past due.
Should your account default, you will be responsible for any and all charges related to being submitted to our collections company, American Profit Collection's.

If you have any questions regarding the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

Patient's Name Printed: _____

Patient's Signature: _____
Date: _____

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