Compassionate Dentistry, P.C.
Scott B. Boltz, D.D.S.
310 East Alto Road, Kokomo IN 46902-3674
765 864-2328 • Fax 765 864-2333

Financial Responsibility Statement

Thank you for choosing us as your dental care provider. We are committed to making your visit with us pleasant. Please read the following information and sign prior to treatment. If you have any questions, please don't hesitate to ask one of our office staff.

Patients With Insurance: I understand my insurance may only pay a portion of the cost of my treatment and **I will be required to pay my estimate on the day of treatment**. This estimate is based on information received over the telephone or online from the insurance company. This is not a guarantee of benefit or payment. If the insurance company pays less than anticipated, or denies my claim, I will receive a statement and it will be my responsibility to pay the remaining amount due. If the insurance company pays more, I will be mailed a refund. As a courtesy, the office will submit a claim on my behalf, but I am ultimately responsible for the total amount due.

Patients Without Insurance: I understand payment in full is expected at the time of treatment unless prior arrangements have been made.

Methods of Payment: Cash, Check, Visa, Mastercard, and Discover. We also accept Care Credit Healthcare Finance. Qualified individuals may be eligible for interest free financing for a 6-month or 12-month period. To determine if you qualify, you may apply here at our office, apply online @ www.carecredit.com, or by calling (800) 365-8295.

Returned Checks: I understand a $30.00 fee will be added to my account balance for any returned checks.

Minor Patients: A patient under the age of 18 is considered a minor. In the event parents are divorced, the parent accompanying the minor is financially responsible regardless of the divorce decree. Settlement must be resolved between the parents.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If treatment needed is part of a lawsuit or claim, we require verification from your attorney prior to your initial visit. We require that you allow us to bill your dental and/or medical insurance, if any. We will not bill your attorney for any charges incurred. You will be responsible for payment in full.

Delinquency and Default Charges: We reserve the right to charge a minimum FINANCE OR DEFAULT CHARGE of $5.00 or at the rate of 1.5% per month, which is an ANNUAL PERCENTAGE RATE OF 18%. This FINANCE OR DEFALT CHARGE will be applied for all accounts that are overdue (90 days from time of service) or otherwise in default under the payment schedule. Reasonable attorney's fees, and other costs and charges, necessary for the collection of any amount not paid when due may also be charged. We may, at our option, without notice, declare the entire principal balance and accrued interest due be payable upon default of one or more payments. We strongly suggest that if there is a financial problem, you contact our office promptly so that arrangements for payment may be discussed.

I have read and understand the financial statement above and agree to accept financial responsibility as described.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Print Name Signature of Staff Member