Acknowledgement of Financial and Dental Benefit (Insurance) Policies
Drs. Cathy and Kevin Mowry, Foundation Periodontics, P.A.

PLEASE **INITIAL EACH ITEM** TO THE LEFT NEAR THE BULLET

- As the patient or responsible party, you are ultimately responsible for the total fees for services, even if a dental benefit company is involved.

- If we are contracted with your dental benefit company, generally only your copayment for treatment will be due at the time of service (Delta, MetLife, Cigna, Guardian, BlueCrossBlueShield of Kansas City).

- A "pre-estimate" or "pre-determination" for treatment is done in some instances to help you determine your financial responsibilities; this however, is not a GUARANTEE of coverage or payment to our office, and you are ultimately responsible for the total of the treatment fee. These estimates often require certain x-rays, which may not be covered by your dental benefit plan.

- Dental benefit companies often place limits on the number of exams, "cleanings," and comprehensive x-ray series that they will provide benefit payment for; this does not mean that you do not need to have additional exams or x-rays, and you are responsible for the fees for those services.

- For patients that do not have dental benefits, or who have benefits with a company we are not contracted with, as a courtesy to you we will file your claims and have you reimbursed for the monies you are eligible for; payment in full to our office by the patient is required in this instance.

- For all patients, outside financing may be obtained in our office through CareCredit and Springstone healthcare financing programs; these can often be used at other dental/medical offices. Our office does not offer "in-house" payment plans or monthly billing.

- If you need to reschedule or cancel a periodontal maintenance "cleaning" appointment with our hygienists, a 24-hour notice by speaking to a staff member is required to avoid a $25 failed appointment fee; a failed periodontal SURGERY appointment in our doctors' chairs will incur a $100 fee.

Patient signature_____ Date_____