Theresa B. Robinson, DMD, PA

FINANCIAL POLICY

Congratulations and thank you! You have chosen our team to assist you in reaching optimum oral health.

We are committed to providing you with the absolute best treatment and payment for our services is a crucial part of your treatment. The following is statements of our Financial Policy which we require you to read, understand, and sign prior to beginning this relationship.

REGARDING PAYMENT

Payment is due prior to services being rendered unless prior written arrangements have been made with the doctor and/or billing receptionist.

We accept the following forms of payment: American Express, bank checks, Care Credit, Cash, certified money orders, Debit Card, Discover, MasterCard, and Visa. PLEASE NO PERSONAL CHECKS.

REGARDING INSURANCE

Your insurance policy is a contract between you (dependent and/or subscriber) and your insurance company regarding eligibility and covered services. As an in network provider we are obligated to follow a set fee schedule. We are not obligated to insure coverage within your policy. We will submit a detailed claim to your insurance company, however, you are responsible for full payment within that contracted fee schedule prior to services being rendered. REIMBURSEMENT, IF ANY, WILL GO DIRECTLY TO THE SUBSCRIBER, NOT TO US.

In the event we do accept assignment of benefits we will collect verified, predetermined copays, deductible, and non-covered charges prior to services being rendered. Should your insurance company not pay us in full within 30 days, the balance will be due immediately, and charged to your credit card account on file (see Pre-Authorized Healthcare Form). Your benefit booklet will have detailed information regarding coverage. There is never a guarantee of payment and coverage is determined only at time services are rendered. A predetermination may be submitted to verify eligibility (not a guarantee of reimbursement for services) prior to beginning non-emergency treatment. In the event of an emergency payment in full is required.

____
Patient/Guardian printed name

____ Date:_____/_______/______
Patient/Guardian signature

____
Witness printed name

____ Date:_____/_______/_______
Witness signature