



Insurance and Financial Policy Agreement

Please read through and initial each paragraph.

INSURANCE: We submit claims to most insurance carriers. Please remember that insurance coverage is a contract between you and your carrier. You, the insured, are responsible for payment on claims that are 1) denied, 2) unpaid due to deductible, 3) partially paid, or 4) specifically partially paid due to the carrier's arbitrary determination of "usual and customary" rates. All balances are due and payable upon receipt. **In-Network Non-Covered Charges:** If you have an in-network insurance plan, there may be some services that are considered non-covered based on the insurance company. These non-covered services are Patient Responsibility and will be an out-of-pocket expense.

COLLECTING BALANCES DUE: You agree, in order for us to service your account or to collect monies you may owe, Zimbi Dental may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any email address you provide to us.

FINANCIAL POLICY PAYMENT: Fees for routine dental services (examination, cleanings and x-rays) are due in full on the date service is rendered unless pre-arrangements have been made with the Office Manager. The patient assumes co-pays, deductibles, and remaining Patient Responsibility.

MAJOR PROCEDURES: All major work over 1.5 hours, such as crown and bridge, dentures, partial dentures, root canal therapy, root planing, or extensive general dentistry may require a full pre-payment/insurance co-payment to reserve your spot.

MINOR PATIENTS: Parents must accompany minor patients to their appointments. For unaccompanied minors, nonemergency treatment may be denied without proper insurance documentation or payment arrangements.

DELINQUENT ACCOUNTS: Delinquent balances will be forwarded to the collection agency after all reasonable attempts to collect have failed. To remain an active patient, it will be expected that you pay the collection fee incurred and may be required to prepay future appointments to bring your account history in good standing.

CANCELLED OR FAILED APPOINTMENTS: We understand that from time to time emergencies arise which may require that you miss a prescheduled appointment. However, our time, and our other patient's time for needed treatment is valuable. Because we have reserved our time specifically for you, we politely request a 24-hour notification to make changes to an appointment. This allows our office time to attempt to fill the vacancy. A history of last-minute cancellations or failed appointments may result in a down payment to hold your next appointment. Missed appointments, and appointments cancelled within 24 hours of your scheduled appointment, will incur a charge of up to \$125 per hour of the scheduled missed appointment. **This amount can be deducted from your pre-paid scheduled appointment.**

COLLECTIONS: If collections become necessary, (collection meaning any balance debt owed to your dental provider not paid within 120 days from treatment unless other financial arrangements have been made), I agree to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs. I understand and agree that Zimbi Dental may send a collector agent to my residence or work to deliver any necessary collection documents.

MEDIATION: Should any claim or controversy arise between me and/or a legally authorized representative appointment by me, and the dentist, or Zimbi Dental, concerning the care and treatment rendered by the dentist to me, and effort shall be made by the parties involved to resolve the dispute through mediation appointed by Professional Insurance Exchange, should the dispute pertain to the quality of the dental services rendered. Costs for the mediation services shall be shared equally by the parties involved. The foregoing mediation agreement does not pertain to actions taken for the collection of debts owed as a result of dental services provided by Zimbi Dental.

I have read this Financial Policy, understand its contents, and agree by signing below to abide by the policy for all services provided by Zimbi Dental

Printed Name of Responsible Party

Signature of Responsible Party

Date