**Financial Policy**

We appreciate the opportunity to serve you! We’ve found that a clear understanding of our financial policy in advance of dental care helps relieve some of the anxiety associated with dental visits. Please read the following carefully and ask us any questions you may have. We will do our best to answer them for you.

* **Patients without insurance coverage need to know…** The fee for the treatment rendered must be paid in full on the day of service.
* **Patients with insurance coverage need to know…** The estimated patient copay and deductible for the treatment rendered must be paid in full on the day of service. Please understand that that you are ultimately responsible for all fees generated by your treatment.
* **We accept Visa, MasterCard, Care Credit, Checks, and cash for payment of the amount due. You can call us and put deposits down on your account to build credits.**
* **24-hour notice is required for rescheduling appointments**. A $50, $75, or $100 fee will be applied to your account depending on the type of appointment being cancelled, canceling, or failing to show up for your appointment without 24-hour notice. Both Dr. Pruitt and Dr. Earp understand that unforeseen circumstances may prevent you from attending your scheduled appointment, however, you must not make missing appointments a habit. Dr. Pruitt and Dr. Earp reserve your appointment time exclusively for you so please be mindful and considerate of this.

This is an agreement between Pruitt & Earp Dentistry, as the creditor, and the Patient/Debtor named on this form. By carrying out this agreement, you consent to treatment by Pruitt & Earp Dentistry and their staff and agree to pay for all services that are received. Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

**The Financial Policy continues on the back of this page.**

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Responsible part (if patient is under 18 years old): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

In this agreement the words “you” “your” and “yours” mean the Patient/Debtor. The word “account”

Means the account that has been established in your name to which charges are made and payments credited the words “we”, “us”, and “our” refer to Pruitt&Earp.

**Treatment Plans:** You understand that if Pruitt & Earp Dentistry has treatment recommendations for, you will receive an itemized list of the recommend treatment. This will also contain an estimate of what the fees will be for the recommended treatment. If you have dental insurance the estimate may include an additional estimate calculating what may be paid by your insurance company toward the fees for your treatment. You understand that treatment plan estimates are not a guarantee of insurance payment, and you are ultimately responsible for all fees generated by your treatment. Please be advised that your treatment plans are only valid for 90 days.

**Payments:** Unless we approve other arrangements in writing, the balance on your statement is due and payable when a statement is issued and is overdue if not paid by twenty-one (21) days after the statement date.

**Past Due Accounts:** If your account becomes past due, we will take the necessary steps to collect this debt. If we must refer your account to a collection agency, you agree to pay all the collection costs that are incurred. If we must refer to collections of the balance to a lawyer, you agree to pay all lawyers’ fees that we incur plus all court cost. In case of suit, you agree the venue shall be in Pitt County, North Carolina.

**Returned Checks:** There is a Fee (currently $25) for any checks returned by the bank.

**Treatment at Other Offices:** Please be advised that when you are referred/ go to a specialist for other services, we do guarantee payment from insurance. This is caused by us not knowing what claims may be pending at the other offices, ultimately resulting sometimes in nonpayment for services provided in our office.

**Insurance:** Insurance is a contract between you and your insurance company. We will bill your insurance company as a curtesy to you. Please note that services are not rendered on the assumption that the insurance company will pay us. You are ultimately responsible for payment of all fees generated by your treatment. If your insurance company has not paid your claim within ninety days after the service, the full amount is due and payable by you. We will promptly refund any insurance payments to you we receive if you have already paid the balance to your account. It is your responsibility to inform us of any changes in your insurance coverage.

**Divorce:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent’s responsibility to collect from the other parent.

**Change of Treatment:** If your treatment is changed to the day of appointment without a 3-day’ notice there will be a charge added to the account for the treatment that is not provided. This amount ranges between $50-100 depending upon the treatment that was initially scheduled. Example: If you plan to have a Crown, Core Build Up, Resin and Crown delivery done and the day of the appointment you decide at check in you would like only to have the Crown delivered this would result in a charge for canceling the other services.

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