



3430 Dodge Street
Inn Plaza
Dubuque, IA 52003
563.556.8388

Financial Policy of Abbadent Family & Cosmetic Dentistry

The Financial Policy of Abbadent Family & Cosmetic Dentistry is very simple. If you receive treatment and you are charged a fee for the treatment, you are ultimately responsible for paying the fee. If you have dental insurance, you may assign payment of your dental insurance benefits directly to this office. Co-pays, deductibles, denials, and remaining balances after insurance pays are your personal financial responsibility. Abbadent Family & Cosmetic Dentistry is a participating provider for Guardian Delta, Dental Premier, WEA, Blue Dental, United Healthcare, and Hawk-1 and therefore honors and abides by the bylaws set forth to the providers of each network.

INSURANCE ASSIGNMENT AUTHORIZATION: (Signature needed only if dental insurance will be utilized) I authorize the release of information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf, and I assign the benefits payable to which I am entitled, to this dental office. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid and as an original.

Signature of Patient/ Parent if a minor

Date

If you do not have dental insurance, payment in full is expected at or before the time of treatment unless prior financial arrangements have been made. We accept cash, checks, MasterCard, Visa, Discover Card, and American Express. We also have several payment plan/ financing options listed below which you may use:

FINANCING PLANS AVAILABLE-You may apply online with any of these companies:

www.carecredit.com

www.healthadvance-online.com (Chase health advance)

www.springstoneplan.com

I understand that if I become delinquent on my account, my account will be turned over to a collection agency, and I will subsequently be reported to the credit bureaus. In case of total default, I promise to pay any legal interest on balances due together with any collection costs and attorney fees incurred to collect on this account.

A fee of \$30 will be assessed for all returned checks.

I certify that I have read, fully understand, and accept the above payment policy.

Date _____ Signature _____



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Abbadent Family & Cosmetic Dentistry Contact Form

Thank you for your support in Abbadent Family & Cosmetic Dentistry. To better serve you please provide the following information and a check mark next to the **best** method of contact.

E-mail Address _____

Mailing Address _____

Home Phone _____

Work Phone _____

Cell Phone (include area code) _____

Text Messaging _____

Thank you,

Abbadent Family & Cosmetic Dentistry