Financial Responsibility Policy

Steven P. Ellinwood, DDS. will file your dental insurance as a courtesy to you!

The contract between you as a patient and your insurance company are personal. Steven Ellinwood, DDS. is not responsible for problems between the patient and insurance carrier.

Steven P. Ellinwood, DDS. credit policy allows up to 90 days for payment by the insurance company. If no payment is received within this time period, you as the patient become personally responsible for payment and communication to your insurance carrier on the delinquent account. We will provide you with information, to the best of our abilities, in seeking reimbursement to you by your insurance carrier. It is your responsibility to pay account balances with the total of any insurance payments made to you directly by the insurance carrier.

Steven P. Ellinwood, DDS. does require that your estimated portions due are paid at the time of service.

Steven P. Ellinwood, DDS. accepts all major credit cards, cash and personal checks. In the event a personal check is returned for insufficient funds, a $25.00 fee will be applied to your account.

Steven P. Ellinwood, DDS. reserves the right to discontinue treatment for non-compliance with payment policies.

Patient Authorization

- I understand and agree to the financial responsibility policy of Steven P. Ellinwood, DDS., and hereby authorize my insurance company to pay the proceeds of any benefits due to me, directly to Steven P. Ellinwood, DDS. I also understand that my insurance carrier may send payments directly to me (or subscriber of the policy) either in error, or because of their contract outline.
- I understand and agree (regardless of my insurance status); I am responsible for any balance on my account for any professional services rendered and supplies provided. I understand further that I am responsible to ensure my bill is paid by my insurance carrier in a reasonable amount of time (within 90 days). Lack of payment, or payment made directly to me (or subscriber of the policy) will result in my prompt personal payment of my statement.
- I hereby agree to promptly pay personal balances on my account resulting from co-insurance or deductible not covered by my insurance company, at time of service.
- I understand and agree that responsibility for the payment of services, and supplies provided in this office, is mine, due and payable. Any financial arrangements that I have made are to be honored as outlined. In the event of default in payment of my account, I agree to pay such collection costs and reasonable attorney fees as may be required to effectively collect the debt.

Patient Signature: _____ **Date:** _____

Parent or Other Responsible Party: _____ **Date:** _____

Relationship to Patient: _____