

Kathryn E. Nicholson, D.M.D., P.C.

2650 Washburn Way, Suite 240 - Klamath Falls, Oregon 97601 - (541) 885-5578

Financial and Appointment Policy

To avoid any confusion about the payment policies of this office, or the utilization of your dental insurance, we have assembled this outline to help answer any questions that may arise. If you have any further questions please ask us.

APPOINTMENTS: As a courtesy to all of our patients waiting for treatment, all scheduled appointments are tentative until personal confirmation is made. To validate your appointment, we require personal confirmation 48 hours prior to appointment time. Our office will attempt to reach you 3 days before your scheduled appointment. Please call our office as soon as you receive our message to confirm your appointment. If you reach our voicemail after hours, please leave a detailed message to confirm. We are very understanding regarding unforeseen business and personal emergencies; however, three short cancellations (less than 24 hours notice) OR failed appointments in a two year period may result in discontinuation from our practice.

Again your appointment will not hold without confirmation.

PAYMENT POLICY: In an effort to make needed services more affordable, it is our policy to require payment when services are rendered. This plan helps reduce your cost and our overhead without diminishing the quality of our services.

- We DO NOT have an open account system of payment.
- Payment is due when services are rendered.
- Payment may be made with cash, check, Visa, Mastercard, Discover, or CareCredit.
- If for any reason an account shows an overdue balance, future treatment may be delayed until the balance due can be reduced to zero.

INSURANCE POLICY: We are happy to accept your dental insurance and work with you and your insurance company.

- **Patients with insurance are responsible for full payment of their accounts.** It is not always possible to predict which services are covered by the carrier or how much will be paid for a particular service. We will assist you in any way possible with your claim.
- We will compute an **estimate** of your percentage of payment at each visit; this payment is due at time when services are rendered.
- Any balance left unpaid by your insurance is your financial responsibility.
- Any questions concerning the reasoning behind insurance payments should be addressed to either your employer or insurance company.
- Please bring a copy of your plan booklet for a more precise estimation of your coverage.
- We will complete and mail your insurance forms as a **courtesy** to you.

I understand that any balance left unpaid by insurance is my responsibility in full, and that interest of 1.5% (18% per annum) is added monthly to unpaid balances over 60 days past due. I agree to pay attorney fees, costs, and disbursements incurred for collection of my past due account, including costs of trial and appeals, and I authorize the release of any information necessary, including but not limited to my social security number, for the collection of the account. I also understand that if my account must be turned over to a collection agency, at that time, my account will be assessed a \$25.00 collection fee. If my account is assigned to Small Claims Court, my account will immediately be assessed a collection fee.

Patient name: _____ Acct. number: _____

Person financially responsible for account (please print): _____

Sign: _____ Date: _____