



Financial Policy

Welcome to Louisville Dental Associates. We sincerely appreciate your trust in choosing us as your dental provider. We strive to provide the best quality service possible and would like to inform you of our office policies and your responsibilities.

Treatment Estimates

The treatment estimates provided to you are based upon the information available to us, from your insurance company. **Please remember that this is only an estimate of the cost of your care.** Please ask the doctor or a staff member if you have any questions regarding your proposed dental treatment.

Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan, and could include but are not limited to:

- Exclusions and limitations of your insurance policy
- Waiting periods
- Use of alternative fee schedules by your insurance company
- Age restrictions
- Previous treatment already billed to your insurance company
- Specific treatment code restrictions

The cost of all dental care is ultimately your responsibility or your legal guardian, regardless of insurance coverage. Insurance Claims are filed as a courtesy. In order to process claims all insurance information must be provided at time of service otherwise payment will be expected in full.

If you have any questions regarding your insurance benefit, we encourage you to contact your insurance company for further clarification. At your request, we will be happy to file an estimation of benefits on your behalf to your insurance company.

All patient portions are due in full on the day your service is provided.

**We accept Cash, Checks, Visa, MasterCard, Discover, and American Express.
We have financing options available thru Care Credit & Springstone.**

Missed Appointment(s)/Cancellation Policy

We have many different ways that your appointments may be confirmed including, phone, email and texting to your mobile device. Please let us know your preference. We kindly ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved time to another patient who would like it. We reserve the right to charge a minimal fee of \$25 per hour for each hour missed, i.e. \$50 for a 2 hour appointment, \$75 for a 3 hour appointment.

Collection Policy

On occasion, after repeated attempts to collect a balance due, we may need to turn an account over to a collection agency. Should this occur, it is agreed that the financially responsible party listed below shall pay all finance charges, collection costs, attorney fees, and any other costs that may be incurred to enforce collection of any amount outstanding.

Patient/Guardian Signature _____ Date: _____