

OFFICE FINANCIAL POLICY

Dental treatment is an excellent investment in the overall dental, medical and psychological well being of adults and children. Ideally, financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that different people have different needs in fulfilling their financial obligations, we are providing the following information about our services and payment options...

*Payment is expected when services are rendered. We accept prepayments as well as cash, checks, credit & debit cards. We do accept most dental insurance and are happy to file your claims for you.*

*Please realize, however, that:*

- *Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.*
- *We will do the best to estimate the amount of your insurance benefit and subsequently the amount for which you will be responsible. We cannot guarantee any insurance benefits.*
- *Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It must be understood that the ultimate responsibility for payment of any services rests with the responsible party for each account.*

Unpaid balances extending 90 days are subject to a finance charge of 1.5% monthly which is an annual rate of 18%, therefore, we ask you to contact your insurance company or our office if you have not received notice of payment within 60 days of services date.

*As a condition for treatment of the patient, the patient and/or responsible party understand and agree to the following:*

- *To pay all payments when due and any late charges thereon.*
- *To notify, in a timely manner, Dr. Murphree's office of any problems of payment.*
- *Treatment may be discontinued for failure of payments on a timely basis, or in the case of nonpayment.*

If you have dental insurance, please complete the following information:

DENTAL INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ SSN \_\_\_\_\_ Relation to patient \_\_\_\_\_

Insured Birth date \_\_\_\_\_ Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Employer HR/Personnel Contact \_\_\_\_\_ Phone \_\_\_\_\_ Ins. Co. \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ Phone \_\_\_\_\_ Contract/Member # \_\_\_\_\_

If you have Double Dental Insurance Coverage, please complete next section.

Name of Insured \_\_\_\_\_ SSN \_\_\_\_\_ Relation to patient \_\_\_\_\_

Insured Birth date \_\_\_\_\_ Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Employer HR/Personnel Contact \_\_\_\_\_ Phone \_\_\_\_\_ Ins. Co. \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ Phone \_\_\_\_\_ Contract/Member # \_\_\_\_\_

If you have any questions regarding the financial policy, please do not hesitate to ask.  
I understand that payment is my obligation regardless if insurance or any other third party involvement.

**Print Patient's Name:** \_\_\_\_\_

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_