SOUTHTOWNE ENDODONTICS, P.C

Practice Limited to Endodontics
45 West 10000 South, Suite 305
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FINANCIAL POLICY

1. YOU ARE FULLY RESPONSIBLE FOR YOUR ACCOUNT.
2. A consultation fee is to be paid in full at your first visit.
3. A portion of the total fee is due at the time of treatment, regardless of insurance coverage.
4. DENTAL INSURANCE: We are happy to file the forms necessary to see that you receive the full benefits of your coverage; however, we cannot guarantee any estimated coverage. Because your insurance policy is an agreement between you and the insurance company, we require that all patients be directly responsible for all charges. Due to the large number of insurance companies that our office encounters, it is your responsibility to know the details, benefits and limitations of your insurance policy. We will do everything possible to see that you receive the full benefits of your policy. If for some reason your insurance company has not paid their portion within 60 days from the start of treatment, you are responsible to pay their portion. You are responsible to pay any balance remaining after your insurance pays their portion as we are not preferred providers with any insurance company. The remaining balance will be authorized by phone and deducted from either a checking, savings, credit or debit card account. (All accounts are to be paid in full within 90 days.)
5. NO INSURANCE: We require a minimum of 20% at the time of treatment. The balance may be set up into 3 payments and deducted from either checking, savings, credit or debit card account. (all accounts are to be paid in full within 90 days.)
6. If you are financed by this office, payment will be deducted monthly and an additional 1½% finance charge per month will be added to the account balance after the first 30 days.
7. Accounts that receive no payments for 60 days will be placed with an attorney for collection and listed with a credit bureau. In the event of default, the undersigned agrees to pay collection fees of an additional 40% of balance owed and legal fees of collection (with or without suit including court costs and attorney fees.
8. PREFERRED PAYMENT OPTIONS:
   *Cash or check: We offer a 5% discount for all treatments paid in full prior to or on the day of treatment. Checks will be electronically debited from your account. I understand and authorize my checks, if dishonored, plus a processing fee with applicable taxes to be electronically debited from my account.
   *Credit Cards: We accept payment by *Visa, MasterCard, American Express and Discover.*

With my signature, I certify I have read and understand the above financial policy, agree to abide by it, and will pay today with: ___Check ____Cash ____Credit Card

SIGNATURE: X _____

DATE: _____

Rev. Oct 04