2139 Dulles Dr. Lafayette, La 70506 – (337)-988-4041
www.ashleypricedds.com

In an effort to provide superior service and clarity we require all patients to complete the following form. This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the highest quality materials and technology available on the market today. We are also committed to providing the most up to date informative and educational tools to allow you to fully participate in maintaining optimum oral health.

This financial agreement is intended to facilitate excellent service to you while minimizing administrative costs. All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between yourself, your employer, and the insurance company. Our office is not a party of that contract. If your insurance does not provide payment for your services within 60 days from your treatment, you will be expected to pay in full.

As a courtesy to our patients, we will be happy to assist you with processing your insurance claims, and we invite you to direct your insurance company to pay your benefits directly to our office.

PAYMENT IS DUE AT THE TIME SERVICE IS PROVIDED!

Your ESTIMATED co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided.

Our office accepts cash, checks, money orders, MasterCard, Visa, American Express, and Discover. Outside financing is available through CareCredit upon approval. All treatment plans are valid for 90 days following diagnosis date. Updating fees are at Dr. Price's discretion.

FINANCIAL POLICY

_____(Initial) All patients are required to provide payment at the time of service. Insurance carriers will be asked to pay their portion of payment. We accept cash, checks, all major credit cards and CareCredit. All sales are final. Visits requiring more than an hour appointment time may require a deposit to reserve your time with the doctor/hygienist.

_____(Initial) I acknowledge that payment is due at the time of treatment, unless other arrangements have been made. I agree that parents, guardians or personal representatives are responsible for all fees and services or items provided to me, to my minor child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

As a courtesy to our patients, we file with all insurance companies at the time of appointments. In accordance with Louisiana law, all claims must be paid within 30 days from receipt of service. Should a claim be denied or not paid within those 30 days, we will submit a 2nd claim to the insurance company. Upon sending this second claim we will contact the patient requesting their assistance in contacting their insurance provider. Payment in full is required 30 days after the 2nd claim is filed (60 days from the time of service). If the insurance company has not paid within this time, the financial responsibility falls to the patient. Your cooperation is greatly appreciated.

_____(Initial) I understand that I am financially responsible for all charges regardless of insurance coverage.

_____(Initial) I understand it is my responsibility to understand the services covered by my insurance provider.

_____(Initial) In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees.

Every insurance policy is unique, and their coverage varies greatly from patient to patient and even appointment to appointment. Even a precertification is not a guarantee of payment.

_____(Initial) Balances older than 30 days will be subject to delinquent fees and finance charge rates of **22.5%** per month. An NSF fee of **$75.00** will be applied to all insufficient fund transactions

BILLING POLICY

_____(Initial) Our billing policy is integrated through Abella. You will receive an email/text message every 14 days with your bill in an attachment. This is our way of billing communication with you. If you choose not to pay through the Abella portal, you are welcome to come into the office and pay or call the office in pay; however; you will receive notifications until the bill is paid.

CONFIRMATION POLICY

_____(Initial) You will receive a reminder phone call from our office two days prior to your scheduled appointment. Your appointment is considered confirmed only when we speak directly to you. If a message is left on a machine or with another member of your household your appointment will remain unconfirmed. We MUST receive confirmation directly from our patients. Your reserved appointment has been scheduled for YOU specifically. If we are unable to make direct contact with you your appointment may be canceled and considered a missed appointment.

Thank you for allowing us the opportunity to care for your dental needs and for choosing to be part of our patient family. We are happy to answer any questions and address any concerns you may have. Please feel free to ask.

Print Name Signature

Date