

Scott A. Terry, DDS

(812) 346-4500

OFFICE POLICIES

Thank you for choosing us as your health care provider. Our mission is to treat patients as guests in our offices with kindness and understanding in order to help provide the treatment and care they need and deserve. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our office policies, which we request you read and sign prior to treatment.

All patients must complete our information and health insurance forms before seeing the doctor.

- FULL PAYMENT IS DUE AT TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD AND DISCOVER.
- WE MAY OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.
- OVERDUE ACCOUNTS MAY BE SENT TO A COLLECTION AGENCY OR SMALL CLAIMS COURT. ADDITIONAL COLLECTION FEES PLUS COURT AND ATTORNEY FEES WILL BE APPLIED.
- THERE IS A \$25 CHARGE FOR ALL RETURNED CHECKS.

REGARDING INSURANCE

We may accept and file assignment of insurance benefits as a courtesy to our patients. However, we do require the deductible and estimated co-pay to be paid at the time of service. The balance and any resubmissions are your responsibility, whether your insurance company pays or not. We cannot bill your insurance company unless you provide us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 90 days, the balance will become your responsibility. Please be aware that some, and perhaps all, of the services may be non-covered services. Certain insurance companies have chosen to send payment directly to the patient. If your insurance company does this, we may require you to pay the entire fee for your treatment at the time of service.

USUAL AND CUSTOMARY FEES

Our practice is committed to providing the best treatment for our patients and it has been determined that our fees are well within usual and customary for this community. Any notification otherwise is a statement that your insurance company is unwilling to pay for the standard of care you have chosen by coming to our office. We will be happy to assist you with correspondence to your insurance company if they refuse to meet this standard.

MINOR PATIENTS

The adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to a Visa/Master Card/Discover or payment by cash or check that has been verified at the time of service.

MISSED APPOINTMENTS

We have a busy practice and our patients are busy too. There is a charge for missed appointments. Please allow at least 24 hours advanced notice for cancelled appointments. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our office policies. Please let us know if you have any questions or concerns.

I have read the Office Policy. I understand and agree to this Office Policy:

_____ Date _____
Signature of Patient or Responsible Party