UT Dentists
A part of UTHealth

Financial Policy Agreement

Thank you for choosing UT Dentists for your dental care. We recognize that providing comprehensive dental services includes discussing all treatment options and associated financial information. We strive to communicate clearly and effectively with you in all aspects of your care. For this reason, we have created a Financial Policy so that you understand our expectations regarding insurance and payment for services. If you have any questions, please address them with the front office staff or practice manager before signing the Financial Policy Agreement.

Accepted Forms of Payment: Payment is due at the time services are rendered. For your convenience, we accept Discover, Visa, MasterCard and American Express, in addition to cash, checks and money orders. A $25 fee will be assessed for returned checks, at the patient's expense.

All account balances must be paid in full before any new treatment is initiated. Estimated patient fees less than $500 are due and payable prior to or at the time treatment is rendered. Estimated patient fees over $500 will require a down payment of 40% of your estimated responsibility before treatment begins. Payment in full is then expected before treatment is completed for any multi-appointment procedures.

Insurance Benefit Plans: As a courtesy, we will file insurance benefit claims on your behalf. However, it is important that you understand that not all recommended dental services are covered benefits and your insurance company does not share financial responsibility for your bill following treatment. You are ultimately responsible for all charges if your insurance company fails to pay for rendered services. In order to accurately estimate your coverage and benefits, promptly notify us of any changes to your benefit plan(s).

Insurance Pre-Estimate, Pre-Determination and/or Pre-Authorization: Before treatment is performed, we will discuss your recommended treatment and the financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees, and to make necessary financial arrangements.

We will do our best to contact your insurance to provide you with your **estimated** portion due, including applicable deductibles, co-payments and/or percentage of the treatments not covered by your benefit plan. However, despite this, we cannot guarantee the payment of insurance benefits nor can we assure 100% accuracy of this estimated amount, since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance company.

Denied or Unpaid Insurance Claims: We will do our best to work with your insurance company to receive reimbursement for your services. However, if an insurance company does not remit payment within 90 days of the service date, you will be responsible for the balance in full. For this reason, we encourage you to communicate with your insurance company about your outstanding claims. Additionally, if the insurance company denies payment on services, and our reasonable attempts to appeal the denial fail, you are responsible for the balance in full. Unfortunately, this sometimes happens even after the recommended treatment plan has been pre-authorized.

Patient Financing: UT Dentists offers patients the option to finance their dental care through a third party vendor. Patients can apply online at home or onsite at the practice and receive a response shortly after submitting the application. For more information, please contact a UT Dentists staff member.

Overdue Balances: Failure to pay for services in a timely manner may jeopardize your access to routine dental care. Future treatment appointments will not be scheduled until delinquent patient accounts are current and in good standing.

By signing below, I have read, understand, and agree to the terms and conditions of this Financial Policy Agreement. I understand that I am ultimately responsible for all professional dental services rendered. I have been given the opportunity to ask questions and have them answered. I am also aware that I may request a copy of this completed (signed) form for my records at any time.

Name of Patient	Signature of Patient or Legal Representative	Date