# JEFFREY B. VAN ORMAN DMD

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## Financial Policy

Thank you for choosing The Van Orman Dental Group for your dental health care. We are committed to providing the highest quality of care as possible. Please review the below office financial policy.

Payment is due at the time services are rendered. The practice depends upon reimbursement from patients for the cost incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services billed to the insurance company are not a guarantee of payment. As a courtesy, we will collect the estimated copayment at the time of service, but any unpaid balance from your insurance will be your responsibility. Insurance companies have a wide variety of rules, limitations, and exclusions that dental offices are not often informed of. We do everything in our power to provide you with the most accurate estimate. Should there be a dispute over a claim, it needs to involve the patient and the insurance company, however, we, will provide any documentation requested by either party. If the insurance hasn't paid within 90 days of the service, the unpaid balance is the patients responsibility.

In consideration for the professional services rendered by this practice, I agree to pay the charges for services at the time of treatment, I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I authorize Van Orman Dental Group to bill my insurance company. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term of condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

By providing my signature, I acknowledge that I have read the above financial policy for The Van Orman Dental Group and agree to the contents.

Signature _____ Date: _____

Relationship to patient: _____