PARKWAY DENTAL CENTER
4701 NICOLLET AVENUE
MINNEAPOLIS MN 55419
612.824.4211
www.allbeautifulsmiles.com

PATIENT PAYMENT POLICY

Thank you for choosing our office. We are committed to providing you with quality and affordable dental care. Please understand that payment of your bill is part of this treatment and care. We proudly offer the following financial policy so that our patients can have the opportunity to decide which payment option best suits their needs.

Payment Options:

- Pay in full with cash or check at the end of the appointment and receive a 5% prompt payment reward.
- Pay in full at time of service with VISA, DISCOVER or MasterCard.
- For patients with insurance your estimated portion is due at time of service.
- Extended-term financial arrangements can be discussed with the office manager or dentist.

Dental Insurance:

We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Recommended treatment is determined by what is best for your dental health. **Our recommendations are based on your dental needs, not your insurance coverage**. Your insurance company may or may not cover all recommended procedures. We request that you understand your policy in advance so that together we can make the best treatment decisions. Please remember that dental insurance is not designed to cover 100% of the cost of your treatment.

Nonpayment:

If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from our office. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative dental care. During that 30 day period, our dentist will only be able to treat you on an emergency basis and require payment in full at that time.

Our practice is committed to providing the best treatment to our patients. Our fees are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Our staff is happy to outline estimates and payment with you anytime and answer any special concerns or needs you have.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party Date