Indianapolis Downtown Dentistry LLC
10 West Market Street
Suite 240
Indianapolis, IN 46204

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. Please understand the payment of your bill is considered part of your treatment. The following is a statement of our financial policy, l which we require that you read, agree to and sign prior to any treatment.

Our policy requires payment in full for all services rendered at the time of the visit. For your convenience, we accept Visa, MasterCard, Discover and American Express. Accounts not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for court cost and reasonable attorney fees, collection agency fees, interest charges and any other expenses incurred in collection or our account.

If you have insurance, we ask that you pay the deductible or the estimated co-payment at the time of service. As a courtesy to you, we will submit the insurance claim for you, however, your insurance is a CONTRACT BETWEEN YOU AND YOUR EMPLOYER OR INSURANCE COMPANY. The insurance company's responsibilities are with the patient. We want to emphasize that as your dental care provider, our relationship is with you, the patient, not with your insurance company.

All charges you incur are your responsibility regardless of your insurance coverage. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not however, enter into a dispute with your insurance company over any claim. If problems arise in getting a claim paid, specific questions should be directed to your insurance carrier or your employer.

Thank you for the opportunity to serve your dental health care needs.

I HAVE READ, UNDERSTOOD AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Patient Name Signature (Guarantor, if minor) Date