Southwest
Dental Associates

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Southwest Dental Associates Financial Policy

Philosophy

It is our desire to provide you with quality dental care at an affordable price. In order to continue to do so, we must avoid unnecessary overhead expenses. This policy is written to assist our practice in serving our patients at the most affordable cost.

For those patients with insurance coverage, we will properly bill your insurance company as a courtesy. Please remember that your insurance contract is between you, your employer, and the insurance company. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We do not dictate our standard of care based on what insurance companies will or will not cover. You and your oral health are our primary concern.

Procedure

We always request payment at the time of service, if you have insurance, your portion is expected. If this is not possible, we expect you to let our credit manager know ahead of time to make payment arrangements.

If your account has not had payment activity in 6 weeks, you will receive a letter and phone call. If no response to this letter, you will be finance charged and a second letter will be sent. If no response, you will receive a third and final letter as well as a courtesy phone call to make payment arrangements. Lack of response will force us to transfer your account to a third party credit bureau where your credit will be adversely affected. We understand that temporary financial problems may arise and effect the timely payment of your account. Should these problems arise, please contact our account manager ASAP and we will work out a new arrangement with you.

Returned checks will have a charge of a $25 fee. Charges for broken or canceled appointments without 24–hours notice may apply. We are disclosing our policy to you so that we may avoid any misunderstanding in the future.

HIPAA

Our dental office is compliant with the HIPAA regulations. The HIPAA policy is available for review upon request.
I have read and understand this policy and agree to comply with the above.

PATIENT SIGNATURE_____ DATE _____