



Terry Scott, D.M.D. & Assoc.
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(972) 540-5858

FINANCIAL POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care and to educate your family on proper oral hygiene in a compassionate, child friendly atmosphere. It is our policy to make definitive financial arrangements with you before any treatment starts. Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask.

1. WE ARE AN OUT OF NETWORK PPO PROVIDER. You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule.
2. PAYMENT IS DUE AT THE TIME OF SERVICE. We accept Visa, MasterCard & Discover. There will be a \$25.00 service charge for all returned checks.
3. You must provide the office with a dental (not medical) insurance card with the proper telephone number and mailing address of the insurance company, or provide a dental (not medical) claim form. If one of these documents is not available at the time of the appointment, you will be responsible for payment of all fees at the time of service. If necessary, we will provide you with an insurance claim form for you to submit for reimbursement from your dental insurance carrier.
4. Your insurance benefits are a contract between you and your insurance carrier. The amount of coverage you receive will depend on the insurance plan purchased, not the fees of the doctor.
5. Our office cannot carry insurance balances longer than 30 days. If your insurance carrier does not pay a claim, you are responsible for the balance in full. A finance charge of \$25.00 per month will be applied to your account on balances that are outstanding for longer than 30 days.
6. After 90 days, we will inform you of a delinquent account with a "courtesy" telephone call. If no action is taken to clear the account, this office will be required to employ a collection service.
7. The parent or guardian who brings the child for their initial visit is responsible for payment, independent of what a divorce decree may state. Reimbursement must be made between the divorced parents. **WE WILL NOT INTERVENE.**
8. Appointments cancelled with less than 24 hours notice will incur a \$25.00 fee, per child.

AUTHORIZATION

I authorize Dr. Terry Scott and staff to release any information concerning my case to my insurance company. I have read and accept the above Financial Policy, understand it and agree to the terms set forth regarding payment.

Patient(s) Name (please print) _____

Name of Parent/Responsible Party (please print) _____

Signature of Parent/Responsible Party _____