STEVEN K JENSEN DDS PC

Written Financial Policy

Thank you for choosing *our* dental office for your dental needs.

We are aware that there are many places you could go for your treatment and appreciate the confidence you have placed in our office.
Dental care is an excellent investment in an individual's well-being.
We are sensitive to the fact that dental care caries with it special cost considerations. Financing issues should not be an obstacle to obtaining this important care.
To avoid any confusion we would like to inform you of our office financial policy.

1) PAY AS YOU GO: Pay your *estimated* amount of each visit according to treatment rendered at that visit.
2) 5% Discount-Pay entire treatment balance at start of treatment. (Cash or Check).
3) 3 EQUAL MONTHLY PAYMENTS (Balances over $300.00)
4) Convenient Monthly Payment Options from Care Credit, Credit Card
   (Subject to credit approval)

You can choose from: Cash, Check, Visa, MasterCard and Discover

Our office is happy to assist you in filing your insurance claims. To do this, we will need you to provide us with information that is relevant to your claim, such as insurance address, policy number, employer birth date, etc. Please do your best to provide us with complete and accurate information. All claims for service will be filed within 24 hours unless you request otherwise. ANY INSURANCE BALANCE LEFT UNPAID AFTER 60 DAYS BECOMES YOUR RESPONSIBILITY. Be prepared to pay the balance.

Please be prepared to pay for services at the time of your visit. If you belong to a preferred provider dental program we ask that you pay your estimated insurance portion in full at the time of service. Many companies have fixed allowances or percentages based on YOUR contract with them, not our office. It is your responsibility to pay the deductible, estimated portion and any other balances not paid by your insurance.

We cannot be responsible for determining your actual dental eligibility for benefits, pre-existing clauses, exclusion clauses, disallowed services, waiting periods, etc. YOU SHOULD CAREFULLY REVIEW YOUR DENTAL POLICY. If you have any questions concerning your dental insurance requirements and coverage please contact your insurance carrier or employer.

We are happy to provide you with an ESTIMATE of the fee for services you require. The final balance after your insurance pays may vary from our estimate due to your insurance payment percentages based on the contract you have with them. We base our fees on the complexity of the problem, the level of dental expertise, as well as the amount of time we devote to your care. Please let us know if you have any further questions. Thank you.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)