Philip H. Iffland, D.D.S., Inc.
A Private Practice of General Dentistry
Providing Restorative, Cosmetic, and Implant Dentistry
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FINANCIAL AND APPOINTMENT POLICIES

This office does not carry balances. Payment is expected at the time services are rendered. Fee quotes and payment arrangements are made prior to each appointment.

We accept the following as payment for services rendered:

CASH
PERSONAL CHECK with DRIVER'S LICENSE and CREDIT CARD
VISA * MASTERCARD * DISCOVER * AMERICAN EXPRESS * DEBIT CARD
CARE CREDIT

We are happy to file and assist with the preparation of insurance forms if you are a subscriber to dental insurance. Insurance payment varies with each insurance contract, and we can only estimate what percentage your carrier will contribute to your investment. We try to be as accurate as possible with our estimates; but they are only *estimates*. The estimated amount not covered by insurance is due at the time initiation date of service. All balances unpaid by your insurance carrier become payable by you 60 days from the initiation of service.

We have no contract with the insurance carrier whatsoever, and although we respect their contribution to your dental care, we will not carry balances due to delays in payment from your insurance carrier. Please read this provision carefully, because it could affect your finances should the insurance carrier not provide payment. It also is to your benefit, as the patient, to take a proactive position in regard to your insurance carrier's responsibilities to provide appropriate and timely benefits.

If you prefer to be on a payment plan, we will be pleased to aid you in obtaining a loan by assisting with loan application and acceptance procedures, and in helping you to choose loan terms. If your investment is over $1250, you may qualify for a 12 month same as cash loan. Please inquire if this would be of interest to you.

We assess a simple interest fee of 1.5% per month on all accounts over 30 days (excluding outstanding insurance payments up to 60 days) and will assess the same 1.5% fee each month until the balance is paid in full. In addition, we assess a $10 Late Fee on accounts that have received no payment activity within the previous 30 days. We prefer not to assess these fees on past due accounts, but must somehow recover the costs of repetitive billing. Please pay your balance when it is due.

Checks returned to us from the bank for non-sufficient funds (NSF) carry a $40 additional fee that will be added to your existing balance. The amount of the check, plus the NSF fee, must be paid in cash before we continue any treatment

(OVER)

We may assess a fee of $75.00 per half-hour of scheduled appointment time, if you fail to keep that scheduled appointment without a 24-hour notice. Failed appointment fees must be paid prior to any further appointments with this office. We also reserve the right to complete treatment-in-progress, and release you as a patient, if you fail to make your appointments. Fees assessed for failed appointments will still remain a collectible debt, as well as any previous balance, should we choose to release you as a patient

We are a private dental practice. There are times when we will run behind in our schedule due to emergencies, Dr. Iffland being called to the hospital, etc. We do our best to remain on time and to assure you that we will be here for you at every appointment. However, we cannot guarantee that we will be perfectly on schedule, that you will never have to wait, or that from time to time, we will not have to change your appointment. We will make every effort humanly possible to notify you at the earliest possible time, should a schedule change arise. Please remember that you may be the patient that Dr. Iffland may have to assist at the hospital, or the patient requiring emergency care. We thank you in advance for allowing us to make those decisions that careful, prudent and thoughtful health professionals sometimes are required to make at the expense of another patient's convenience.

We WELCOME you to our practice and thank you for your patience in reading our Financial and Appointment Policies. Now that the necessary formalities have been finalized, we can begin the process of assessing your dental health which is, after all, the reason that you have to come to our office, and the reason we are here for you.

Your signature below acknowledges that you have read and understand all of the aforementioned, and accept all of the aforementioned in total. Further, your signature acknowledges that you have asked any and all questions in regard to our Financial and Appointment Policies and have received complete answers that you fully understand.

PATIENT SIGNATURE DATE

SIGNATURE OF PARTY RESPONSIBLE FOR ACCOUNT (If Other Than Patient) DATE

IF THIS FORM IS BEING COMPLETED FOR A MINOR (under age 18),
SIGNATURES OF ALL PARTIES RESPONSIBLE FOR THE ACCOUNT ARE REQUIRED.

MOTHER'S SIGNATURE DATE

FATHER'S SIGNATURE DATE

SIGNATURE RELATIONSHIP DATE

SIGNATURE RELATIONSHIP DATE