Office Financial Policy

As a courtesy to our patients, we at Jourdain Dental Care are willing to file your dental claim on your behalf (direct billing), and may accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. You may find that our fees may be different from the insurance company's schedule of "allowable" fees, which are arbitrarily set by the individual insurance companies, and may result in a difference in the amount covered by your insurance plan. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of insurance coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.

In order to accept assignment from your insurance carrier, it is the policy of the office to maintain a valid credit card on file at all times. This information will be kept securely on our computer system and will require password authentication in order to access. So that we may keep our costs as low as possible, we ask that your insurance co-payment portion be paid at the end of each visit, unless alternative arrangements have been made prior to your visit. If the co-payment amount is not known at the time of your visit, once the payment has been received from the insurance carrier charges under $300 will be directly billed to your credit card and a receipt will be forwarded to you.

☐ I agree to the above and would like to leave the following credit card information on file:

☐ Visa

☐ Mastercard

Print Cardholder Name	Card Number	Expiration Date

☐ I agree to leave the card on file as above, but will pay my balance owing by alternative means (cash, cheque, debit card) at the time of service.

☐ I do not have a valid credit card. I will not commence with treatment until my co-payment amount is known (preauthorized) or I will pay the full amount at the time of my dental visit.

☐ I do not wish to leave a credit card on file, and understand that I will pay the full amount owing at the time of treatment. The dental office will still file the claims on my behalf, but payment will come directly to me.

I hereby authorize payment directly to Jourdain Dental Care of the group insurance benefits that would otherwise be payable to me. I understand that I am ultimately responsible for all cost of my dental treatment. I have read the above and understand the office financial policies. I agree to the terms as they have been laid out above.

Patient Signature: _____ Date: _____

Staff Signature: _____