

Phillip F Sehnert, DDS, PA
501 West Main Street
Lewisville, Texas 75057
972-420-0042

FINANCIAL POLICY

Dear Patient:

Thank you for selecting us as your dental health care provider. Our office wants all of our patients to comfortably be able to afford the dental care they need. Our primary goal is that you receive the optimal treatments needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to ask a member of our knowledgeable staff. Please remember, this office is always an "Out of Network" provider for any insurance plan.

Payment for services is due at the time services are rendered. We accept cash, personal checks, and for your convenience Mastercard, Discover, American Express, Visa and CareCredit. We also offer a 5% discount to those patients willing to pay for treatment in full and in advance of treatment with cash or check. As a courtesy to you, we will file your insurance and accept assignment of benefits as long as we have complete insurance information at the time of your visit.

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are **NOT** a party to that contract. Our financial relationship is with you, not your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will and will not cover.
3. Fees for these services, along with unpaid deductibles and co-payments, are due at the time of treatment. We make every attempt to give you the most accurate **estimate** based on the benefit information your insurance company provides us.
4. If the insurance company does not pay your balance in full within 30 days, we will request that you contact your insurance company or Human Resource Division to aid in the process.
5. If the insurance company does not pay in full within 60 days, we will require you to pay the balance due with cash, personal check, Mastercard, Discover, American Express, Visa or CareCredit.
6. Balances older than 90 days may be subject to additional collection fees and interest charges of 1.5% per month (18%APR). Returned checks will have an additional fee of \$30 .00 added to the amount of the returned check and if unpaid, will be turned over to the Denton County Hot Check Division. **All** fees related to debt collection will be the responsibility of the patient or guardian.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us so that we can assist you in the management of your account. Again, thank you for choosing Dr. Sehnert as your dental health care provider. We appreciate your confidence in us and the opportunity to serve you.

I understand that all balances are due at the time services are rendered unless one of the arrangements listed above have been made with our financial coordinator. I further understand that beginning with the first day of the month following your balance becoming sixty (60 days past due, a monthly charge of 1.5% (18% APR) will be assessed to any unpaid balance. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Patient's Signature: _____ Date: _____