Bob Schmidle, D.D.S

Financial Policy

Thank you for choosing Dr. Bob Schmidle and his staff to help you maintain your oral care and improve your overall wellness.

It is our policy that all fees including deductibles, co-pays, and non-covered services are due on the date of service unless other payment arrangements have been made with our office.

As a service to you we will file a claim with your dental insurance company. Please make sure we have a current copy of your insurance card. If you do not provide us with the correct insurance information on your date of service and your claim is denied, you are responsible for payment. It is your responsibility to verify if Dr. Schmidle is considered a preferred provider in your plan.

Accounts which are not paid within a reasonable period of time, and for which no special arrangements have been made, will be subject to placement with a collection agency following due notice.

Having read and understood the above policies, I agree to the terms set forth. I understand that I am financially responsible for all charges, even if they are not covered by my insurance plan. It is my responsibility to know what my insurance carrier considers a covered expense and frequency limitations set by my plan. If my insurance does not pay the full charges for services performed on a given date, it is my responsibility to pay the difference. In the event I do not pay my balance in timely manner and my account is sent to collections, I agree to pay all costs of collection, including attorney fees.

I, the patient or guarantor/guardian, authorize the release of all applicable dental information including, without limitation, copies of all records and test results produced to other healthcare practitioners or organizations which will be providing subsequent monitoring, care, or treatment in connections with care provided by Dr. Bob Schmidle and his staff. I accept the responsibility for the dental charges incurred by the patient and agree to pay all fees listed above at the time of service, unless other arrangements are made. I authorize the practice to render dental treatment and to release information to process insurance claims and to determine benefits. I also authorize my insurance benefits to be paid directly to Dr. Schmidle. I further agree that a photocopy of this document is to be considered as valid as an original.

Signature of Responsible Party: _____ Date: _____

Printed Name: _____ Relationship to patient: _____

Patient Name (if different from above): _____