

**Shelley Shearer, D.M.D., PLLC**  
**Financial Responsibility & Payment Policies**

Thank you for choosing us as your dental care provider. We are committed to providing you with quality and affordable dental care. Because some of our patients have questions regarding patient and insurance payment responsibilities for our services rendered, we have developed the following financial responsibility and payment policies for you and your use. Please read it, ask us any questions, and acknowledge receipt below. If you would like a copy for your records, please ask our Front Desk staff.

**Patient Information:** All patients will be asked at each visit to provide any updated information regarding their address, phone number, insurance policies, and place of employment, and medical history.

**Insurance:** As a service to you, we will file insurance claims to your carrier for primary and secondary insurance carriers. We participate in most insurance plans in the area. If your insurance changes please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Please understand that your insurance coverage is a contract between your and employer and your insurance company. The quality of your plan is based upon the level of coverage your employer chose to purchase for you. Our office cannot change your dental benefits; but we can help you maximize the benefits you have.

If you are not insured by an insurance plan, payment in full is required at each visit.

X \_\_\_\_\_

**Patient Pay Amounts:** Co-payments and deductibles required by your insurance coverage must be paid at the time of service. Co-payments and deductibles are part of your contract with your insurance company. Please help us by paying your co-payment at each visit. **You will be required to pay the day you receive dental treatment.** Prompt payment allows us to control our costs.

X \_\_\_\_\_

**Unpaid Balances:** Patients refusing to remit payment or make payment arrangements after 30 days notice will force us to apply an 8% finance charge, not to exceed the Kentucky State limits of 12%.

X \_\_\_\_\_

**Collections:** Past due accounts over 90 days with no payments from you may be turned over to a collection agency. If your account is sent to a collection agency you will be required to pay that balance in full prior to receiving any future treatment.

**NSF Checks:** Bounced checks will be charged back to your account with a \$25.00 service fee. We reserve the right not to accept checks for payment in the future.

**Bankruptcy:** You will be required to pay cash for all services rendered, even if you have insurance. After payment from your insurance company you will be refunded for any overpayment.

**Non-Payment of Agreements:** If you have an agreement with our office to make regular payments we reserve the right to expect payment in full if this agreement is broken.

**Insurance benefits will be attained prior to first visit. All co-pays and deductibles are an estimate by your insurance company. You may still owe a balance after the insurance company pays their portion.**

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges in our area.

Thank you for understanding our payment policy. If you have any questions or concerns please contact our office any time.

I have read and understand the payment policy and agree to abide by its guidelines.

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Signature

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Date