HOLLINGER DENTAL GROUP

Financial Policy and Agreement

Thank you for choosing Hollinger Dental for your dental needs. We are committed to providing you with excellent care and convenient financial arrangements. We encourage you to be an active and informed participant in your own care. Accordingly, financial arrangements are the result of open and honest discussions of diagnoses and recommended treatment options. To confirm your understanding and agreement with our policies, please read the following:

Payment:

Payment in full is due at the time services are rendered, unless prior financial arrangements have been made. We accept Visa, MasterCard, and Debit. Remote payment is also available. With your consent, a secure link will be shared with you and payments will then be processed through a third party. Cash and personal cheques are also accepted.

Estimates:

We will do our best to provide you with an estimate for the cost of any dental procedure. These are merely estimates because it is often impossible to know exactly how much a specific treatment will cost until after it is done. For example, a cavity may appear small on a radiograph but when the decay is removed, it is possible that the required filling is larger than originally anticipated. Similarly, it may appear that a tooth needs a root canal, but if the dentist observes a fracture during the procedure, he or she might need to change the treatment plan.

Insurance:

Our office is committed to helping patients get the most benefit from their dental insurance, however, insurance policies vary greatly. Therefore, due to the complexity of insurance contracts, you are fully responsible for knowing your own insurance plan and what treatment it does and does not cover. Treatment is recommended based on what you need; not based on insurance coverage. As a courtesy, we will gladly send your claim electronically for you, on your behalf, to your insurance company provided that your company allows electronic submission. If your insurance company fails to pay the claim, you continue to be responsible to pay for all services rendered in full.

Dependents:

A parent, guardian, or caregiver must accompany all dependents who are unable to consent to treatment to their dental appointments. Every dependent will have a designated responsible party who is responsible for full payment of the services rendered. If the responsible party does not accompany the dependent to the appointment, treatment consents and payment arrangements must be made prior to appointment or non-emergency treatment may be denied.

Missed Appointments:

Once an appointment has been made, a room is reserved specifically for you and the dentist/dental hygienist's time is set aside. Please be considerate of other patients and our clinic and allow at least twenty four hours to reschedule or cancel an appointment and two weeks for any specialist appointments in order to avoid a service fee. Service fees may be applied to patients who miss appointments without notice at a rate of $50-$200 and will depend on the expected appointment duration.

Service Charges:

We understand that temporary financial problems may affect timely payment of your balance in some cases. In those situations, we encourage you to communicate any such problems immediately with our Office Manager at 705-267-1020, who can be reached during regular business hours.

Financial Consent and Authorization for Treatment:

The estimate provided at time of service is not an exact calculation of your actual costs and does not reflect all of the terms, conditions, limitations, and exclusions that may apply to your insurance coverage. We cannot guarantee payment or coverage of your claim. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the services received. By signing this form, I acknowledge that I understand the following:

- I agree to pay all fees and charges for services rendered at Hollinger Dental for the patient listed below.
- I agree to pay all charges when presented with a statement for the patient listed below, unless prior credit arrangements are agreed upon in writing.
- I understand and agree, regardless of my insurance, that I am ultimately responsible for any unpaid balance on the patient's account.

Patient Name: _____

Responsible Party Name(s) (if applicable): _____

Signature of Patient/ Responsible Party: _____

Electronic Communication

□ I agree to receive email and/or text messages from Hollinger Dental which may include appointment confirmations, newsletters, upcoming events and important notifications. *

*You may withdraw your consent at any time by emailing our Office Manager at: manager@hollingerdental.ca