Payment Information

Our fees are meant to be fair and reasonable. We strive to keep them that way. You assist that effort when you pay for our services at the end of your visit. Our office staff can tell you the approximate fee for treatment before your appointment. To make payments easier for you, we accept cash, personal check, Visa, Mastercard and debit cards. We also offer a payment plan.

We will cooperate fully with all our patients who are covered by insurance plans. Dr. Thomas assumes no responsibility should patient (parent or guardian, if minor) err in the utilization of their insurance according to their insurance companies rules, regulations, limitations and requirements. It is important that you understand that in most cases your insurance is designed to reduce your cost, not eliminate it completely. You are ultimately responsible for the full amount of your bill regardless of your insurance coverage. Please note that there are a few insurance companies that will not reimburse the doctors directly, necessitating payment in full at the time of service. Some examples are: Blue Cross Blue Shield, Mamsi, and Delta Dental.

Patients who are covered by insurance are expected to pay an estimated copay based on a percentage of the total charge at the time of the visit. Payment for exams is requested at the time of service. Any insurance payment not received after sixty days of filing becomes the responsibility of the patient. Payment from the patient is expected within ten days of notification.

I understand that if payment is not made when the account is due, there will be a finance charge of 1 ½% per month (18% APR) and the account may be turned over for collection. I will be responsible for any and all costs associated with the collection process, including but not limited to billing costs, collection fees, lawyers fees and court costs.

NOTE: Accounts will be turned over to a collection agency if the balance is not paid in full within 60 days.

A **$25.00** charge will be added to your account for all **RETURNED CHECKS**.

I have read and understand the above.

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Signature of patient (Parent or Guardian if Minor) **Date**