Nikki Christian & Wesley Christian
DENTISTRY

Thank you for choosing our dental office!

The following is a statement of our **Financial Policy**. We base our financial arrangements on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities.

IF YOU HAVE HEALTH INSURANCE COVERAGE…..

- You are responsible to supply us with correct, current insurance information
- Please notify us of any changes in your address or telephone number
- Your **estimated** portion, including any deductibles, will be expected at the time of service
- You are ultimately responsible for payment of all charges whether or not such charges are covered and paid (either fully or partially) by your insurance company.

IF YOU DO NOT HAVE HEALTH INSURANCE…or IF YOU REQUEST A COSMETIC PROCEDURE…

- Payment in full is due at the time of service
- We accept cash, check VISA, MC, DISCOVER, AMERICAN EXPRESS, health savings and flex account cards
- Care Credit: third-party zero and low interest financing company

Our business office is available from 8:00-5:00 Monday through Friday to answer any questions. If you receive a statement from our office, then we expect payment from you. If you disagree with the balance for any reason, please contact us immediately.

A parent who brings a minor child to our office for dental care is responsible for payment of all of the child's charges.

A $35 fee is charged for returned checks.

I hereby guarantee payment of all charges for dental treatment and services provided to me (or my dependent) at this office. I understand and agree that if the office places my account with an agency or attorney for collection, the office shall be paid by me for all collection costs to the extent allowed by applicable law.

I HAVE READ AND AGREE TO THIS FINANCIAL POLICY:

_____Date _____

Signature of Patient or Responsible Party

****Credit/Debit/Health Savings/Flex/ACH Policy****

Patient Name_____

Patient Account #_OFFICE USE ONLY____

I understand it is the policy of this dental office to secure my credit or debit card information at the time of my visit. The office acknowledges that we must comply with the provisions of U.S. law.

If, after a claim has been submitted to my insurance carrier: **1)**the claim is denied for any reason; OR **2)**there is a patient liability (i.e. deductible, co-insurance, etc); The office will send a statement notifying me of the balance due. If this amount is not paid within 30 days, then my credit or debit card will be charged for the **entire balance** owed for treatment of services provided to me or my dependent.

I understand my insurance company will also provide notification of these charges with an explanation of benefits. In the event this amount exceeds $250, the office will provide a courtesy call to my home number.

I understand that in the event my credit or debit card has been charged for dental treatment or services, and then my insurance carrier subsequently makes payment to the office for those charges, the office will issue a credit to my credit or debit card.

Please circle one of the following:

VISA/MC/Discover/American Express **OR**
Checking/Savings Account/Health Savings/Flex Account

Last 4 Digits of Card/Account Number:_____
Expiration Date:_____
Name of the Cardholder:_____

I hereby authorize Nikki Christian, DDS LLC and its designated employees to charge my debit/credit card or account as designated above, the patient responsibility and/or denied amount for dental treatment provided by my office. The charge will be based on the dental treatment rendered to me (or my dependent) and the usual and customary charges made by the office for such treatment. If payment is denied by my credit/debit card or banking institution, I will pay the entire amount within 30 (thirty) days.

_____Date_____

Cardholder's Signature