Jennifer A. Neise, DDS, PC

3132 W SR 38 Pendleton, IN 46064

Ph. (765)778-7585

Office Financial Policy:

Payment is due at the time services are rendered. For your convenience we accept, cash, Visa, MasterCard, Discover, Care Credit, personal check, money order, or registered check.

Insurance benefits are determined by your employer and not your dentist. Any deductible or estimated co-payment amount will be due at the time of treatment. Insurance is not a guarantee of payment as insurance companies will not pay for all your costs.

Your insurance policy is a contract between you and your insurer. Your insurance and payment are still your responsibility. As a courtesy, we will be glad to file your claim for you if you bring your insurance card and all required employer information. You will be expected to pay for services rendered if the office is unable to verify your coverage before treatment.

If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible. Interest of 1.75% monthly will be assessed for the outstanding balance.

We reserve the right to charge and collect fees of $50 for failed appointments if appointments are cancelled or broken without 24 hours noticed. Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

Returned check fee of $30.00 will be added to your account balance and is collectible. Payment plans and financial arrangements can be entered into for comprehensive dental treatment prior to commencing treatment.

I certify that I have read the above information to the best of my knowledge. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third-party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. In consideration for the professional services rendered to me, I agree to pay any collection or legal fees incurred due to not paying my bill in a timely manner. I agree to be responsible for payment of all services rendered on my behalf or my dependent.

Patient
Signature: _____ Date: _____