Paul J. Steele, D.D.S., P.C. Financial Policy

Thank you for choosing Dr. Steele as your Endodontist. We are committed to providing you with quality and affordable healthcare. The following is our financial policy. Please read it and ask us any questions you may have. A copy will be provided to you at your request.

PATIENT RESPONSIBILITY: Procedures that require pre-authorization must be authorized prior to services being rendered and it is the responsibility of the patient to find out if a prior authorization is required. We participate in many insurance plans. Knowing your insurance benefits and confirming our participation with your plan is the **patient's responsibility**. Please contact your insurance company with any questions you may have regarding your coverage. (As a courtesy Dr. Steele's office will file to any and all insurance companies and help with any questions or intervention necessary to assist our patients.)

PROOF OF INSURANCE: All patients must complete our patient information form before having exams or services. We must obtain a copy of your driver's license and a current, valid dental insurance card. Failure to provide this information prior to your visit will result in patient responsibility of the services in full. Please bring these items to each visit.

CO-PAY, CO-INSURANCE, AND DEDUCTIBLES: Payment of co-pays, deductibles, and co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure to do so may be considered fraud. For your convenience, we accept cash, check, Visa, Mastercard, Discover, and Care Credit.

CLAIMS SUBMISSION: As a courtesy, we will submit your claims. Your insurance may require additional information from you in order to process the claim. Failure to comply with their request within 30 days will result in full patient responsibility for the claim.

NONPAYMENT: Unpaid accounts will be referred to an outside collection agency.

SPECIAL HANDLING: Accounts will not be held due to special circumstances such as law suit settlements, injury settlements, attorney requests, etc. The accounts must be paid by the patient then recovered by the patient from insurance, attorney, estate, or settlements of any kind.

Thank you for reviewing our financial policies. Please sign in the spaces provided below to acknowledge receipt of this information.

ASSIGNMENT OF BENEFITS: I authorize direct payment to be made to Dr. Steele's office for any and all dental services rendered. I also authorize the release of any medical records for the purpose of healthcare operations.

FINANCIAL POLICY: I have read and understand the financial policies of Paul J. Steele, D.D.S., P.C. and agree to abide by its guidelines:

Patient's Printed Name:_____ **Birthdate:**_____

Signature of Patient or Responsible Party:_____ **Date:**_____