Dr. James B. Tankersley, Jr.
Upstate Dental Surgery

Financial Policy

Our patient's care and comfort is of the utmost concern to this practice. In order for us to provide the highest quality care with today's rising costs, we established a financial policy for our patients.

Payment for your exam, extractions, and x-rays is due at the time of treatment. If this exam is for future surgery, we will provide an estimate of your surgery charges. At the time of surgery, if there is no insurance coverage, we will ask that the account be paid in full. If there is insurance coverage on the charges, we will ask that the responsible party pay the yearly calendar deductible amount and the co-payment amount as stated in your policy. We are not a participating provider for any HMO's or PPO's. As a courtesy, we will be happy to submit your insurance claims with all of the necessary medical reports and x-rays. Your insurance information will be needed at the time of your initial consultation appointment. A consultation charge of $25.00 plus any x-rays is due today.

Insurance companies typically use what is referred to as usual and customary fees to determine the maximum amount they will cover for a particular procedure. Any difference in the amount they will cover, and our fee is the responsibility of the patient. You will receive monthly statements until your account is paid. If your account is not paid in full within ninety (90) days, it will be considered delinquent. After one hundred twenty (120) days from treatment, delinquent accounts will be turned over to a professional agency for collection. Being turned over to a collection agency may damage your credit rating and significantly influence future purchases.

Under special circumstances, a payment plan may be established with our front office. We do accept Visa; MasterCard and post dated checks. When paying by check, we ask that you agree that your account may be debited electronically for both face amount and returned check fees if returned unpaid.

If your insurance pays more than your account balance, a refund payment will be issued to you.

If needed, we will submit a pre-authorization for benefits to your insurance carrier. This pre-authorization will determine if your insurance covers the recommended treatment and provide an estimate of what benefits can be expected for the procedures.

I have read and fully understand the financial policies of this practice.

_____	_____	_____	_____
Patient Signature	Date	Responsible Party Signature	Date