Dr. Claude A. Hearn, DMD
Financial Policy

Patients with Insurance:
We will gladly submit your claims to your insurance company as a courtesy to our patients. You will be responsible for your estimated portion and deductible if applicable at the time of service. Please remember that the insurance portion is ONLY AN ESTIMATE. You will be financially responsible for the remaining balance. Dealing with insurance companies can sometimes be difficult, it is impossible for us to determine the exact amount of insurance coverage. You as the policy holder should be familiar with your dental benefits. Some insurance companies may not cover all procedures and they may also downgrade their fees for certain procedures, that you may be responsible for the difference. So, please be aware of what your policy states. If you have any questions concerning your policy, please call your dental insurance company. If you should have a credit on your account, you may contact us, and after all claims are paid, we will be more than happy to send you a refund check or you may have the option to leave that credit on your account for any further treatment that may be done.

Insurance Companies that we are contracted with:
We are currently contracted with several insurance companies. Please contact the front desk for further information on who we are in network with.
Same Day Cancellation Fee: A $50.00 cancellation fee will be incurred for those who cancel within the same day of their appointment.
Patients with NO Insurance:
Payment is due in FULL at the time services are rendered. Unless other financial agreements have been made and signed off on with either the Doctor or the Office Manager.
Payment Methods:
We accept cash, check, Visa, MasterCard, Discover and CareCredit. There will be a $35.00 or 5% (whichever is greater) service charge on all returned checks. The patient will be responsible for any cost incurred in the collection of an unpaid balance. And, we have the right to charge an Interest rate of 1.5% per month on any unpaid balance past 90 days. If you have any concerns or questions about payment please feel free to discuss then with our Office Manager.

I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

Patient Name____________________________________
Signature of Responsible Party____________________**Date**________________
Relationship ____________________________________