JASON J. AUGUSTINE
D.D.S., M.S., P.C.
4025 W Bell Rd #4, Phx AZ 85053
Phone: 602-978-6910

Financial Policy Notice

Patient name: _____Date:_____

Thank you for choosing Jason J Augustine for your periodontal/implant care. We believe our financial policies support our commitment to excellent personalized care and financial clarity. The following policies are required to be read and initialed indicating that you understand and agree to our policies before your initial visit with us today. Please feel free to request a copy for your records.

- _____I understand that I have dental insurance which when billed on my behalf should reimburse the office for my treatment as outlined in my policy.
- _____I understand that it can take up to 6 weeks for my insurance to process a claim.
- _____I understand that it is my responsibility to pay all co-pays, deductibles, con-insurance and uncovered procedures that apply. This balance must be paid within 30 days after my insurance has paid their portion.
- _____I understand that if for any reason my insurance company does not pay for the services provided within 90 days, that I shall assume full responsibility for the total amount owed.
- _____I understand that my insurance company does not guarantee a payment even when a pre-determination is received and that their final determination is made upon receipt of an actual claim for services performed and based upon available benefit at that time.
- _____I understand that my social security number is required separately from my insurance ID number for the submission of claims in this office and will not be used for any other purpose than claim submission or collection of delinquent debt and will not be shared per our privacy policy.
- _____I (we) understand that if I (we) default on payment, an outside collection agency may be used. I (we) understand that I (we) will be responsible for collection fees up to 50% of the outstanding balance. I (we) also understand that interest of 2% per month shall be charged on the outstanding principal balance. I (we) also understand should suit be brought against me, I (we) will be responsible for court costs and attorney fees.

- _____I understand 60 days after insurance has paid collection activity will begin with no further
  notice and I will be charged $25 per month for administrative fees.
- _____If we cannot verify your insurance you will be expected to pay in full and self submit to your insurance.

We accept cash, checks, Master card, visa, Discover, American Express and debit cards.

There will be a $35 fee for returned checks. Postdated checks are not accepted.

We do not keep cash on hand to make change so please be prepared to bring your exact amount.

We confidently recommend the Care Credit Company, an independent medical lender. They offer several low interest or no interest payment plans to assist you in making payment more budget friendly. Please ask us for their current brochure.

Patient Name: _____

Patient (or guardian) signature: _____

If the patient is a minor:

Responsible Party Name (please print):_____

Responsible party signature: _____

Date: _____