

DeVries Family Dentistry  
415 Main Street  
Brandenburg, KY 40108  
(270) 422-1181

## Payment Policy Agreement

**Payment for your dental care is expected at the time treatment is rendered.**

**FINANCE CHARGE:** A finance charge of 1 ½% per month (18% per annum) or \$.50, whichever is greater, will be charged on all accounts with unpaid balances exceeding 60 day from the date of service.

**MEDICAID PATIENTS:** Patients that have Medicaid through the state of Kentucky must present, before treatment, their Medicaid card for the current month and their Passport Card. For some adult patients a **\$2.00 co-pay** will be due for each visit to the office. This is noted on your Medicaid card by an \* next to your name. Without both cards treatment can only be done at the patients' expense.

**INSURANCE PATIENTS:** As a courtesy to our patients we will file your insurance. In order to do this you must provide your insurance card and benefit booklet. It is the responsibility of the patient to know the limits of your insurance. **You will be expected to make payment at time of service for any deductible or cost share for your treatment.** We cannot guarantee what your insurance company will pay. We will estimate as closely as possible what your out of pocket expenses will be.

I certify that I (or my dependent) have insurance coverage and authorize benefits, otherwise payable to me for services rendered, to be paid directly to the doctor. I understand that my insurance carrier may pay less than the actual bill for services.

**I agree to be responsible for payment of all services rendered on my or my dependents behalf.**

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_