Financial Policy

Zsambeky, Chaney, & Associates

5000 Hwy 49 South
Harrisburg, NC 28075

220 Branchview Dr. SE
Concord, NC 28025

***** I understand that your practice is not currently In-Network with ANY dental insurance company, and I will be billed for any balance that the insurance does not pay for my appointments *****

The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

ALL emergency dental services, or any dental service performed without previous financial arrangements, must be paid for in full at the time services are rendered.

We accept CASH, CHECK, CARE CREDIT, VISA, MASTERCARD, and DISCOVER.

As a courtesy to our patients, this office will prepare and file the patient's insurance forms, assist in making collections from DENTAL insurance companies (WE WILL NOT FILE TO MEDICAL INSURANCE), and credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient, and he or she is personally responsible for payment of all dental services not paid by the insurance company.

As the patient, I understand that due to insurance policy changes and/or necessary changes in treatment plans, the insurance coverage may vary from the estimated treatment calculation. I acknowledge that this is an estimate only, and I understand that I, not the insurance company, am ultimately responsible for payment in full for all services rendered.

I understand that all services are due to be paid in full within sixty (60) days of the date of service, whether or not my insurance benefits have been received. Should my account exceed sixty days, one and one-half percent (1.5%) interest per month (18% per year) will be charged. There are no guarantees of insurance benefits.

I grant my permission to your or your assignee, to telephone me at my home, work, or personal number to discuss matters related to this form.

I have read the above conditions of treatment and payment, and I agree to their content.

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Printed name of patient/parent/guardian

______________________________	____________	______________________________
Signature of patient/parent/guardian	Date	Relationship to Patient

I certify that a member of the office staff offered to explain questions I have regarding this form.

______________________________	____________	______________________________
Signature of patient/parent/guardian	Date	Relationship to Patient