FINANCIAL POLICY
Jody S. Harrison, DDS, MS, PLLC

As validated by your signature on the bottom of this form, you understand and agree that:
Your balance is due immediately after treatment is rendered*.

*For large cases such as dental implants and complex surgery requiring multiple visits, payments will only be made for the completed portions of treatment.

Dr. Jody Harrison's office will file, update and refile claims with your dental insurance company according to your dental insurance company's policy. We will be glad to help you with your claim, even well after your appointment.

Your benefits payment (from dental insurance) will be sent to you when your claim is completed.

If asked, we will request a predetermination from your dental insurance company to determine your eligibility and coverage for a procedure. It is an estimate only. Predeterminations from your insurance provider(s) are NOT a guarantee of payment.

Dental insurance is a contract between the patient, their employer (if applicable) and the insurance provider. Submitting claims for payment to the insurance provider is a courtesy provided by the dentist, not an obligation. Ultimately, you are responsible for any treatment that is unpaid by the insurance provider.

We have a third-party financing available through Wells Fargo and Care Credit. We are happy to discuss them with you and help you with your application. Such options are regulated by the rules and policies of the third-party.

A returned check fee may also be applied and must be payable from you for each check payment returned to us by your bank.

Estimates and treatment plans are based upon information gained from the examination. As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. This is a preliminary estimate only.

Estimates do not take into consideration any money that was billed toward your financial maximum or treatment limits that may have been used at other dental offices.

As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. We will make an effort to anticipate any changes in the treatment plan and advise you at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible. We will make every effort to accommodate your scheduling needs.

Signature: _____Date: _____

I have read, understand, and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all fees for services rendered to me and/or my family.