



Elkhart Periodontics and Implants LLC

Financial Policy

Effective: September 2025

Please bring this completed form to your appointment.

We thank you for allowing Elkhart Periodontics and Implants LLC to be part of your health care team and dental family. Excellent dental care comes from our dedication to your needs and comforts, as well as from our dedication to maintaining open and honest communication regarding our current office and financial policies.

Please read and initial each paragraph on the line provided.

PAYMENT

Payment is expected in full at time of service unless prior financial arrangements have been made. We accept cash, personal checks, Visa, Mastercard and Discover credit cards. There is a 3% processing fee when paying with credit cards; there is no additional fee when using cash, personal checks, HSA/FSA cards, or debit cards. Patients with an outstanding balance more than 90 days overdue must make payment arrangements prior to scheduling appointments. Patients are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason. For patients who have made prior financial arrangements, payments are due by the 25th of every month. Quoted fees in treatment plans expire on December 31 of the calendar year in which they were given. Missed appointment fees are a minimum of \$75 or 10% of the procedure, whichever is greater.

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INSURANCE

We are not in-network with any insurance company, but we will file on behalf of the patient as a courtesy. We will file up to two times per claim, after which, it will be the patient's responsibility to file with their insurance company. It is the patient's responsibility to provide us with current insurance information and to present an active insurance card at each visit. Elkhart Periodontics and Implants LLC is committed to helping our patients maximize their benefits. However, please remember that your dental insurance is your responsibility. Pre-determinations will be filed upon the patient's request. As a courtesy to you, we happily manage two claim submissions. We must stress though, that the patient remains responsible for the total treatment fee. In the event that the patient's insurance

company has not paid within 60 days, the patient will be responsible for the balance. If you have questions about how to maximize your benefits within our practice, a team member is always available to help.

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PAST DUE ACCOUNTS

It is our policy to charge a \$35 late fee for every month that payment has not been made. After 90 days of no payment being made on the account, the patient will then be turned over to a collection agency. The patient/patient's account holder will be responsible for all costs and expenses of collection including, but not limited to, legal fees and interest accrual.

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PAYMENT PLANS

For procedures completed by Dr. Hill:

A minimum of 35% of that day's procedures are due at the time of service. Balances on accounts can be set up for a payment plan based on the amount owed. Payment plans are an **automatic debit to a credit/debit card only**, on the 25th of each month, for the agreed upon amount. Balances are the remaining 65% of procedures after 35% down payment.

For LANAP (Laser Therapy)/LAPIP (Laser Therapy – Implants) Procedures, a minimum payment of 35% is due day of procedure.

For SRP Procedures, a minimum payment of 50% is due day of procedure.

Unless balance is paid in full, a signed payment plan is required. Any missed payments will result in \$35 late fee to be added to the account. Missed payments will be expected in full along with next full monthly payment. After 3 months of missed or failed payments, patient will be turned over to collections. Accounts not paid in full by agreed upon due date will result in 30% interest charges applied every month to the account until paid in full. Unless otherwise agreed upon, any additional fees/services accrued during the life of the payment plan, will be added to the balance of the plan. Auto debit will continue until balance is paid in full. Auto debits will not be more than the agreed upon amount without the permission of the card holder.

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ADDITIONAL INFORMATION

Please call if you have questions about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having difficulty paying your bill, please contact our office to discuss your options. Satisfactory arrangements can almost always be made.

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BY SIGNING

I agree to accept responsibility for payment of fees submitted to my insurance carrier, and for any balance not covered by my insurance. **I accept the responsibility to know my insurance plan's provisions.** I am responsible for payment regardless of my insurance company's arbitrary determination of usual and customary rates. I am responsible to address specific coverage issues with my insurance company's member service department. I agree to all of Elkhart Periodontics and Implants LLC Financial Policy. I understand that I am responsible for payment for all services provided to me by Elkhart Periodontics and Implants LLC. I understand that my insurance may deny or delay payment for these services or only partially pay them, and I agree to pay for the balance if that happens. I agree that I am legally responsible for my account and all costs associated with the collection of my account. A collection fee, attorney fee or any other fee that may incur to collect payment will be added to any outstanding balance. I authorize the practice, all associated dentists and all associated agencies, to gather, maintain and release any and all of my information that may be required for the processing of any and all claims for third party payers. I authorize Elkhart Periodontics and Implants LLC to release information concerning diagnosis or treatments to my insurance carrier, to submit fees for services rendered to my insurance for payment, and also direct payment to the Provider(s) who rendered dental services.

(Signature of patient) (Printed name of patient) (Date)

(Signature of witness) (Printed name of witness) (Date)