Kircher
FAMILY DENTISTRY

Patient Name: _____

FINANCIAL AGREEMENT-PAYMENT FOR SERVICE

Payment for procedures can be completed with check, cash, credit card and/or insurance. Your estimated portion for your investment is due in full on the day of service. If you have any questions about your payment responsibilites, please call our office at 319-524-1431 and talk to one of our office managers. Sixty days after the date of service there will be a charge of 1.5% per month. A returned check fee of $35 will be added for any returned check.

If there is a remaining balance after insurance has paid its portion, the remaining balance will be due in full within 30 days. If no payment is received, collections proceducres will start. If the account goes to small claims court it can add $100 or more to the cost. If there is a credit on account after insurance has paid you can either choose to receive a refund or you can leave it on account for future use.

Dr. KALI KIRCHER IS NOT A PROVIDER FOR MEDICARE.

INSURANCE:

Patient is responsible for being aware of what benefits are available to them with their insurance company. We will not be respsonsible for coordinating benefits between primary and secondary insurances, deductibles, co-insurance, reasonable and customary fees or anesthethesia coverage benefits. Kircher Family Dentistry will request information of benefits from your dental insurance prior to treatment. Many insurance companies do not give all the information needed on our inquiries. Our business office staff can only provide an estimated amount. We will send in any documents needed or explination of any type to help process your claim. We will assist you with your claim, but it is **YOUR** responsibility to pursue unpaid claims promptly. If the insurance does not process the claim within 90 days you will be responsible for the amount. There are circumstances where there is more than one insurance to process, or additional information is needed, etc. and we will allow more time in order for the claim to process.

PAYMENT:

In the cases of divorced parents, the parent bringing the child into the office will be deemed responsible for payment. I hereby authorize the payment of insurance benefits directly to the office of Kircher Family Dentistry and Dr. Kali B Kircher, DMD. I realize that I am financially responsible to this office for all charges not covered by insurance. If I do not have dental insurance coverage, I acknowledge that I will be resposible for payment in full the day services are rendered.

AGREEMENT:

I agree to pay the amount charges by the dentist for all professional treamtent and service. If the fee for service is not paid within 90 days, I agree to also pay all costs of collections, including, but not limited to, collections fees, attorney's fees and court fees.

PRINT NAME:_____

PATIENT/GUARANTOR SIGNATURE & DATE:_____

RELATIONSHIP TO PATIENT (circle one): SELF PARENT LEGAL GUARDIAN