



John R. Strief D.D.S

501 12th Avenue Suite 200 * Coralville, Iowa 52241 * PHONE: (319) 337-2241 * FAX: (319) 337-3382

FINANCIAL POLICY

This agreement is between John R. Strief D.D.S., as **creditor**, and the **patient/guarantor** named on this form. By executing this agreement, you are agreeing to pay for all services rendered by our office.

MONTHLY STATEMENTS: If you have a balance on your account, you will receive a monthly statement with a due date of **15th**. It will show your current balance and **monthly finance charge of 3% on balances over 60 days**. **Payment is due at the time services are rendered.**

PAST DUE ACCOUNTS: If your account becomes past due, we **will** take necessary steps to collect this debt by means of a collection agency and/or attorney. Past due accounts are classified as over 90 days with no active payments.

INSURANCE CLAIMS: We will gladly submit your claims and will assist you in receiving the maximum benefit from your plan. **All plans, however, have limitations, deductibles, and some may not cover 100% of the fees for our services.**

IT IS YOUR RESPONSIBILITY TO KNOW THE REQUIREMENTS OF YOUR INSURANCE COMPANY. THIS INCLUDES PARTICIPATION, IN-NETWORK, OUT-OF-NETWORK, REFERRAL REQUIREMENTS, SECOND OPINION, PRIOR APPROVAL, PRE-CERTIFICATION AND OUT-PATIENT AND/OR IN-PATIENT STATUS. YOU ARE ALSO RESPONSIBLE FOR ALL CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLE REQUIRED BY YOUR INSURANCE PLAN. YOU MUST BE AWARE OF ANY PRE-EXISTING CONDITIONS, WAIVERS OR WAITING PERIODS, AS OUTLINED BY YOUR INSURANCE CARRIER.

DENTAL LABORATORY WORK: Many times, the laboratory work will be completed before insurance claims have been paid. All dental laboratory fees are due as the work is delivered to us. For treatment requiring lab fees, partial payment at initial appointment will be needed and the remaining will be due at the time of completion.

CO-PAY: Co-pays are due at the time of service. Your contract with your insurance company requires that you pay all co-payments and deductibles. Failure to comply, could lead to loss of insurance coverage. Please note co-pays reflect an estimate for the out-of-network insurances and additional payment may be due after the insurance claim has been processed.

MONTHLY PAYMENT OPTIONS:

- Cash, check, credit/debit card (Visa, MasterCard, Discover, American Express) or money orders. **This excludes all USA government sponsored payers: Ex: Title 19.**
- In addition, you may use **UICCU Platinum Financing**, which is designed for extensive treatment or large balances. We also offer Care Credit and The Lending Club. Please ask the front desk for more information.

UNINSURED PAYMENT OPTIONS: Payment is required in full on the date of service. A **10%** discount will be given for balances paid in full on the date of service using cash, check, money order, or credit/debit card.

EFFECTIVE DATE: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and this agreement will be in full effect.

Patient Signature

Date