Patient Financial Policy

Lake Crest Family Dentistry
2321 John Hawkins Pkwy., Suite 221
Hoover, Alabama, 35244-3543
Phone # 205-989-5889

- Always bring your current dental insurance card with you
- Please notify is at least 48 hours prior to your scheduled appointment of any changes in insurance
- Please pay your co-pay and/or deductible at the time of service. Patients without insurance coverage must arrive prepared to pay for services rendered in full.
- Unable to present a valid member identification card from your insurance carrier, we will expect you to pay for your services in full until coverage has been verified.

1.5% FINANCE CHARGE WILL BE BILLED MONTLY FOR BALANCES OVER 60 DAYS.

No Dental Insurance : All balances are due at the time services are rendered. We accept cash, checks and CC. Financing is available through CareCredit.
Insurance Subscribers : It is responsibility of the cardholder to know the terms, eligibility and coverage of their insurance carrier. We suggest that the card holder verify the coverage limitations a prior to the appointment date. Although we make every effort to "estimate" what your insurance company may pay for your services, it is the insurance company that makes the final determination of your eligibility. Your insurance contract is an agreement between you and your insurance carrier. You are responsible for the payment of deductibles, co-payments and any non-covered services at the time of your office visits. In-office treatment "estimates" are based on general benefit information available and are not a guarantee of coverage or payment.
Divorce: In case of divorce/ separation, the parent authorizing treatment will be responsible for subsequent charges.
Past Due Accounts: All balances "over 30 days" are considered past due. If your account becomes delinquent we will take necessary steps to collect this dept. All "90 days past due" accounts are subject to referral to collection agency. You agree to pay all of the collection and attorney fees that are incurred. All referred accounts will incur a minimum $50.00 fee and be reported to the Credit Bureau.
Returned Checks: There is a fee of $50.00 for all returned checks. This amount may change and is in sole discretion of Lake Crest Family Dentistry.
Waiver of Confidentiality: You understand if we need to submit your account to an attorney or collection agency, have to litigate in court, or if your past due status is reported to a credit reporting agency , the fact that you received you received treatment t our office may become a matter of public record.
Transfer of Records: Records release requests will not be processed on delinquent accounts.
Effective Dates: All terms and conditions are in full effect immediately post of signing this contract.

I have read this Patient Financial Policy as outlined, and agree to all terms and conditions listed above. This is an agreement between Lake Crest Family Dentistry as creditor and , the patient/guardian or parent as debtor, named on this form. In this agreement "you"," your" and "yours" mean the patient/debtor. The word "account" means the patients account established in your name to which charges are made and payments credited.

By executing this agreement , you agreeing to pay for all services that are rendered.

Patient / Guardian Signature _____ Date _____

Patient / Guardian Name Printed _____

Prior to implementation the policy and notification process have been approved and met the requirements of the Alabama Dental Society.