Strasburg Family Dental
Financial Policy

Dear Patient,

At Strasburg Family Dental, providing quality dental care for our patients is our first priority. We make treatment recommendations based on your dental needs, independent of what your insurance plan may cover. When possible, we will provide treatment that falls within your insurance coverage and we are willing to explore ways to do this if you let us know each time of service precisely what those guidelines are.

In order to meet the needs and requests of our patients, we are enrolled in numerous insurance programs. As a courtesy to you, we will bill your insurance company directly. Each insurance company has plans that differ depending on the type of contract you and/or the employer negotiated with the insurance company. It isn't possible for us to know the individual requirements and coverage for each plan.

If you do not know or do not inform us of any special requirements in your insurance contract and we render services that are not covered, we are required by your insurance company to bill you directly for those charges. Payment for those charges will be your responsibility.

We understand the patient frequently does not know what is covered and what is not. We are often able to provide an estimate of coverage based on your insurance plan, but this will be an estimate only. The estimated patient financial responsibility portion is due on the date services are provided. Once your insurance company has paid their portion of the services provided, any outstanding balance will be due and owed by you. Please be aware that we have no control over payment processing times by your insurance company. We allow 60 days from the date of service for the receipt of payment from your insurance company. At that time, the entire balance is due on the account and will be billed to the person financially responsible for the account. We accept Cash, Check, Credit Cards and Care Credit as forms of payment.

With your cooperation and help, you should be able to receive the insurance benefits offered to you and we will be able to concentrate on caring for your dental needs.

Thank You,
Strasburg Family Dental

I have read and understand the financial policy stated above and agree to accept responsibility as described.

Patient/Guardian Signature: _____Date: _____