

P. Bruce Easter, D.D.S., P.C.
3935 Eagle Creek Pkwy, Suite A
Indianapolis, IN 46254
Phone: 317.291.1000 Fax: 317.291.3400

FINANCIAL POLICY

Thank you for choosing our practice as your health care provider. We are committed to providing the utmost in caring and quality treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to **read and sign** prior to any treatment.

WE ACCEPT CASH, CHECK, VISA, MASTERCARD AND DISCOVER. Use of other sources also accepted include credit unions, banks, finance companies, along with Care Credit.

Regarding Insurance

Payment is due at the time of service. If you have dental insurance, we accept assignment of insurance benefits after co-payments and deductibles are met. Please supply us with a copy of your **insurance plan book** so we can accurately **estimate** the portion of the bill not covered by insurance. Regardless of payment by your insurance, **payment is due in full within 30 days** of service. Your insurance is a contract between you and your insurance company and their payments should be monitored by you for timely payment. We are not a provider to any type of dental networks (PPO'S/ DMO'S).

If you choose to file your insurance yourself, we will grant you a **5% courtesy fee reduction**, when the entire balance is paid in full at time of service. You may pay with check or cash, and a completed dental insurance form will be provided for you to submit.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and our fees are in the usual and customary range for our area. You are responsible for payment regardless of any company's arbitrary determination of usual and customary rates.

Missed appointments

In consideration of our patient's schedules, we ask that you choose an appointment time you will be able to keep. We understand that emergency situations arise occasionally and will take that into consideration. We ask that you provide our office with a **24 business hour cancellation notice**, as that time is reserved for you. In the event of a failed or canceled appointment without 24 business hours notice, our office will assess a \$25.00 fee and \$50.00/hour fee for appointments 1 hour or longer.

Interest

We reserve the right to charge interest in the amount of 1.5% per month (18% APR) for all balances not paid in full within 30 days.

By signing below, I understand this financial policy and agree to proceed with my dental care. I also agree to a fee of \$25.00 being charged for all NSF checks returned to our office. Furthermore, I agree that if this account is turned over to an attorney or collection agency, I will be responsible for all collection fees, 18% APR interest, court costs, and reasonable attorney fees. I also agree and assign any/all insurance benefits to be paid directly to Dr. P. Bruce Easter, D.D.S., P.C.

SIGNATURE _____ DATE _____