Alliance Endodontics
2287 Raleigh Ct Ste A
Clarksville, TN 37043

Financial Policy

Please Initial on each line

1._____Unlike your general dentist, as a specialty practice, we may only see you as our patient for one treatment visit. Therefore, payment is due at the time services are rendered. As a courtesy, if you have dental insurance we will bill your carrier, provide documentation, claim forms, radiographs, and treatment narratives. However, if your insurance does not pay, it is your responsibility to complete the payment. We will collect your estimated co-payment at the time of service. We accept cash, checks, Visa, MasterCard, Discover & American Express. We also work with Care Credit, where you can have deferred interest and fees for 6 months, if you would like to pay it off more slowly.

2. _____ Those with dental insurance: We will estimate the portion your insurance is going to pay. Since this varies for each individual, usually 25 - 75% of the cost of the procedure is required at the time of service. **We will bill your insurance for you, however, finding out the specifics of your particular coverage (such as if you are in/out of network) is ultimately your responsibility. NOTE: *If your insurance company does not reimburse us after 2 submissions, you will be responsible for the remainder of the balance since we were unable to collect from them.***

3._____Insurance companies routinely indicate that coverage verification does not guarantee payment. This means while we have done our best to estimate your out of pocket expense, when the insurance company processes the claim, the insurance payment may be substantially less than expected. For this reason, we will collect 5% above the estimated out of pocket to accommodate for under-payment by the insurance company.

4._____ If your insurance pays **more** than the estimated amount, a refund check will be mailed to you within 2 months from the date all payments are processed. If, for some reason, your refund is not deposited, you will be charged a $25 fee to re-issue the check.

5._____ If your insurance pays **less** than the estimated amount, you will receive a statement from this office. We will send 3 statements in an effort to collect for services if there is a balance on the account. If the balance is not paid during this time, the account will be sent to collections. I understand that the collections agency will collect processing fees and interest and that the charged amount will increase over time.

6._____Broken appointments: Many people see us because they are in severe pain and want to be seen immediately but a specific amount of time is reserved especially for your dental needs. We require 24 hours notice to avoid a $100.00 cancellation fee.

If you have questions regarding your account, please contact us at (931) 553-8484. Many times, a simple telephone call will clear any misunderstandings.

Signature_____ Date_____