Brad R. Hobson, DDS, PLLC

Financial Policy

We are committed to providing each patient with the best possible care. If you have dental insurance, we will help you receive your maximum allowable benefits. In order to do this, we need your assistance, and your understanding of our financial policy.

Regarding Non-Insured Patients

Payment is due in full at the time of service unless prior arrangements have been made.

Regarding Insured Patients

The estimated non-insurance portion (co-pay) for treatment rendered is due at the time of service. While the filing of insurance claims is a courtesy to our patients, all charges are your responsibility from the date the services are rendered. If your insurance company has not paid on your account in 90 days, the balance will be expected in full. If you're insurance company sends you the check for Dr. Hobson's services, you are required to pay the day of service in full

We will gladly discuss your proposed treatment and answer any questions relating to your insurance, however, please understand.

- Your insurance is a contract between you and your employer, and the insurance company. We are ***not*** a party to that contract.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain service ***they*** do not cover.

We accept cash, check, Visa, MasterCard, American Express, and Discover cards. Information regarding extended payment plans through Care Credit is also available. Returned checks may be subject to an additional fee. After 30 days all accounts are subject to a Finance Charge of 1% monthly on the unpaid balances.

If you have any questions about any of the above information or are uncertain regarding insurance information please do not hesitate to call, we are here to help you.

I understand and agree that (regardless of my insurance) I am responsible for the balance on my account for the dental services rendered. I have read all of the information on this sheet.

NAME (please print)_____

SIGNATURE_____ Date_____

PARENT/ GUARDIAN (if minor)_____ Date_____