John E. Crosland, D.D.S.
Financial Policy

Thank you for choosing John E. Crosland, DDS as your periodontal care provider. Our practice is committed to providing the best treatment to our patients. Please understand that payment of your bill is considered part of your treatment. The following is the Financial Policy of John E. Crosland, D.D.S. The practice requires each patient to read and sign prior to any treatment. All patients must complete our Information and Insurance forms before seeing the Periodontist.

The practice accepts assignment for commercial insurance. However, any charge incurred is the responsibility of the patient. The practice will bill for all charges incurred, but the patient is responsible for all co-pays, co-insurance amounts, and deductible amounts specific to your insurance policy. The practice expects payment for estimates of patient's responsibility at time of service. However, all exam fees are to be paid by the responsible party at the time of service. The practice cannot bill the insurance carrier unless you provide the practice with the correct insurance information.

Your insurance policy is a contract between you and your insurance company. The practice is not a party to that contract. After the practice has received information of the denial or payment of your insurance, the practice will bill you for the remaining balance. If you are unable to pay the remaining balance in full, please call the business office to arrange a payment plan. If you have not made prior arrangements, or made an effort to pay the account following payment from your insurance carrier, after three billing cycles the account will be turned over to collections or small claims court.

The practice accepts cash, check, or credit card payments. In addition to these methods of payment, the practice will offer alternative payment arrangements for those patients without insurance with a demonstrated dental and financial need.

In the event your check is dishonored or returned for any reason, you authorize us to electronically or by paper draft re-present the check to your bank account for collection of the amount on the check, plus any applicable fees as permitted by state law

I have read the Financial Policy. I understand and agree with the Financial Policy.

X_____ Date_____
Signature of Patient or Responsible Party

X_____ Date_____
Signature of Co-Responsible Party