Holloway
Family Dentistry
Jeremy Holloway, DMD

FINANCIAL POLICY

INITIALS

_____ **PAYMENT OPTIONS:** Payment is expected at the time services are performed. For your convenience, we accept cash, personal checks, VISA, MasterCard, American Express, Discover and Care Credit. Applications for Care Credit are available at our front office.

_____ **EMERGENCY TREATMENT:** All emergencies must be paid in full at the time of treatment. Weekend and after-hour calls will include an extra fee in addition to the regular fee for service.

_____ **DENTAL INSURANCE:** As a courtesy to our patients, our office will assist you in obtaining the maximum benefit from your insurance and file your claim. Once your plan coverage has been verified, we will accept assignment of payment from your insurance company. Most plans cover only a portion of the dental fee which means you will be responsible for your deductible and the portion we estimate your plan will not cover. **Payment of your portion is expected at the time you are in our office for dental care.** We are an out-of-network provider.

If your insurance company has not paid our office within 30 days, we will refile your claim. If your insurance company has not paid within 60 days, we ask you take responsibility for payment.

Please sign below to allow us to file your insurance claims. Also, please have your insurance card ready for us to copy for our file.

I hereby authorize Dr. Jeremy Holloway to release to my insurance company information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Jeremy Holloway. I understand I am responsible for any unpaid balance.

_____ _____

Signature of Patient/Insured Date

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy and I understand and agree to the Financial Policy.

_____ _____

Signature of Patient or Responsible Party Date