

Financial Policy

Jessica L. Bishop, DDS, PA
6015 Farrington Road Suite 102
Chapel Hill, NC 27517
(919) 489-2793

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following statement is our financial policy, which we require you to read and sign prior to any dental services being rendered.

1. We accept cash, check, Visa, MasterCard, Discover, American Express and Care Credit.
2. Unpaid balances, after 90 days, will accrue interest at 18%.

Regarding Insurance:

We do not accept assignment of your insurance benefits. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. As a courtesy, we will file all dental claims for you. Payment is required at the time of service for all services.

Please be aware that some, and perhaps all, of the services provided may be deemed non-covered or not medically necessary under dental insurance programs.

Missed Appointments:

Please help us serve you better by keeping appointments. Unless cancelled at least 24 hours in advance, habitually missed appointments will be charged at the rate of \$50 per hour.

Minor Patients:

The adult parent accompanying the minor is responsible for payment of the minor patient's account regardless of who the insurance policy holder is. For unaccompanied minors, non-emergency treatment will be denied unless the minor is prepared to pay when services are rendered.

I authorize Jessica L. Bishop, DDS, PA to release any information, including the diagnosis and records of any treatment(s) rendered to me or my child, to my insurance company(s) necessary to process claim. I also authorize and request my insurance company(s) to make payment of any dental benefits directly to Jessica L. Bishop, DDS, PA

Thank you for understanding the necessity of our financial policy. Please let us know if you have any questions or concerns regarding the above financial policy.

I have read, understand and agree to this financial policy.

Signature of patient (if patient is under 18 a parent must sign)

Date