Concho Valley Family Dental

Jay E. Fandel DMD

Financial Policies

Payment Options:

Payment is due at the time of service. We accept cash, checks, and major credit cards. We offer an outside financing option known as Care Credit. A Payment Plan may be utilized in accordance with our Office Policies. All emergency dental services or any dental services performed without previous financial arrangements must be paid in cash at time of services.

Insurance:

The Doctor and his Clinical Team follow the "Standard of Care" set by the State Board of Dental Examiners to assure patients the best care possible. At the time of service, our office will estimate the patient portion based on benefit information given prior to the visit. The patient/responsible party will be expected to pay the estimated portion at the time services are rendered. This portion is only an ESTIMATE. Our office will prepare insurance claims and assist in collecting from your insurance company. All money paid to the office will be credited to the patient's account.

If an insurance over-payment occurs or the insurance requests to be refunded, we will refund the insurance company and the account will be charged. If there is an over-payment by the patient, a refund check will be mailed to the patient. In the event the insurance sends payment directly to the patient, it is the responsibility of the patient to remit payment to the office immediately. After 90 days, the patient/responsible party will be responsible for any remaining balance.

This office cannot render services under the assumption that our charges will be paid by an insurance company. Patients who carry dental insurance must understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for all charges incurred, even in the event the procedure or procedures are deemed by your insurance as non-covered procedure/s.

Collection Policy:

Should your account become delinquent and turned over to a collection agency, the patient/responsible party will be responsible for any collection fees incurred as well as the balance owed.

I understand the Financial Policies and I am in agreement.

Signed:_____ Date:_____

Patient or Responsible Party

2102 Pecos St. Suite 1, San Angelo, TX 76901
325-944-4984