David J. Schrad, D.D.S., P.C.
1415 Harney St Suite 100
Omaha, NE 68102
(402) 341-7576

CITY VIEW DENTAL

FINANCIAL AGREEMENT

Our office understands the value of insurance benefits, and we are happy to assist you in filing the necessary forms. This is done as a courtesy to our patients and there is no guarantee of coverage. The insurance carriers base the amount of benefits on a fee schedule that they arbitrarily develop. For this reason, you may receive less of a benefit than we estimate for you. Your insurance policy is an agreement between you and your insurance carrier; therefore, all patients are directly responsible for all charges. Once your insurance carrier has paid, you will be responsible for any difference upon receipt of our statement. If, for any reason, your insurance carrier has not paid within 90 days from the date of treatment, you are responsible for the entire balance at that time.

CHILDREN OF DIVORCED/SEPARATED PARENTS

Unless you give us a signed, notarized court order to keep on file, the parent that brings the child in for their visit will be considered ultimately financially responsible for that visit. Anyone else who might bring your child in for a visit also assumes this responsibility. We entrust you to tell us whom the bill needs to go to for any remaining balance after your insurance pays. Please keep in touch with the office whenever financial responsibility changes for your child. We will work with you as much as possible.

CANCELLATION AGREEMENT

Our office requires a 24 hour notice for any cancellation. This is so we can allocate other patients in need of urgent dental care. A fee will be charged if less than 24 hours' notice is given. The fee is entirely the patient's responsibility, and is not covered by your insurance.

PAYMENT

Payments are expected as services are rendered. Payment and charges made at the time of services are estimates until your insurance carriers and the provider have made the appropriate adjustments to your account. Insurance companies may deny your claim, at which time you will be responsible for the whole balance.

We accept the following: Cash, Check, MasterCard, Visa, Discover, American Express, or Care Credit.

I have been given a copy of the financial policy and agree to be bound by its terms. I also understand that such terms may be amended from time to time by the practice, at which time the practice will give me verbal/written notification of such amendments.

I understand my financial obligation as outlined above. I am aware that any balance outstanding after ninety (90) days is my responsibility. The treatment plan has been explained to me and I have agreed to the terms as listed.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness for David J. Schrad DDS, PC. Date