

Financial Responsibility

Robert E. Hawkins, D.M.D.

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about your financial responsibility.

1. **All patients must complete necessary forms before seeing the doctor**
2. **Full payment or co-payment is due at the time of service.**
3. **We accept cash, check with a driver's license or state ID (There is a \$25 service charge on all returned checks), Visa, Mastercard, Discover, American Express, and CareCredit card.**
4. **Our office has a \$35 charge for any Missed Appointments(unless it is an emergency, or any other acceptable circumstance, etc).**

Insurance

We will accept your estimated insurance co-payment at the time services are rendered. Insurance companies will not guarantee payment on any claim until it is submitted and reviewed; therefore, upon receipt of payment or a denial of payment from your insurance company, we will reconcile your account for any balance due or credit payable to you. If your insurance company has not paid its portion in full within 30 days, we ask that you contact your insurance company or your employer to help expedite their review and payment on your claim. If your insurance company pays you in error, the check must be forwarded to our office for submission. After 30 days, you are responsible for payment in full immediately.

Insurance is a contact between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered services, secondary coverage, etc., other than to supply factual information as necessary. You are ultimately responsible for the timely payment of your account. Any delinquent accounts will be sent to our legal team. Thank you for your understanding. If you have any concerns, do not hesitate to ask our office staff.

(Patient Signature or Legal Representative)

(Date)