Kimberly C. Andersen, DDS
6704 Sterling Ridge Drive, Suite G
The Woodlands, TX 77382

Financial Policy

We value you as a patient and are committed to providing you with the best possible dental care. We want you to have a complete understanding of your financial responsibility for the services to be provided. To assist us in achieving this, we ask that you review our financial policy.

Unless payment arrangements have been approved in advance by our authorized staff, payment in full is expected at the time services are rendered. As a courtesy to you, we will file a claim with your primary insurance plan and can accept assignment of benefits. This can be done after we have had the opportunity to verify your insurance benefits.

At the time of your appointment, you will be expected to pay your deductible as well as any portion of the treatment fees that we estimate will not be covered by your insurance policy. Because of insurance policy changes and/or necessary changes in treatment plans, your dental coverage may vary from this estimated treatment calculation or your carrier's pre-estimate. **Please remember that your insurance is a contract between you and your insurance company and/or employer. Our dental practice is not a party to that contract.** If you are unsure of your financial responsibility, please contact your insurance company, in advance, to obtain this information.

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment. Even if the parents are divorced, the parent that accompanies the minor to the doctor is responsible for payment, regardless of the terms of the custodial agreement.

We see parties on an appointment basis and we request that you call in advance so we can reserve time for you. We make every effort to honor all time commitments and ask that you extend the same courtesy to us by letting us know 24 hours in advance if you are unable to keep your appointment.

If your check is dishonored or returned for any reason, there will be a $30.00 charge assessed to your account. Your use of a check is your acceptance of this agreement and its terms.

All treatment charges are ultimately the responsibility of the patient or responsible party regardless of insurance coverage. **If your insurance company has not paid the full balance of the claim within 60 days from treatment date, you will be responsible for paying the balance.** In the event of non-payment, the patient or responsible party agrees to pay all the costs of collection including, but not limited to, attorney fees, court costs, collection agency fees, etc.

I have read and understand the financial policy of this practice and I agree to be bound by its terms, I also understand and agree that such terms may be amended from time to time by the practice.

Signature of Patient/Parent/Guardian_____ Date _____

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