Dr.Jonathan Jenkins, DDS., MS

Practice Limited to Periodontics & Implant Dentistry

**FINANCIAL POLICY**

*Please read our office financial policy and sign in agreement at the bottom of this sheet.*

*If you have any questions or concerns, please let us know.*

*The following is a statement of our Financial Policy which we require all patients read and sign prior to any treatment including your initial exam.*

**Payment for Services:**  Payment is due at the time services are rendered. We accept cash, check and credit cards (Visa, Mastercard & Discover). We will extend a 5% discount on any payments made by cash or check. We also accept payment through Care Credit for those who qualify. Care credit is a payment program offering a full range of No interest plans for your dental treatment. We require that any services not covered by your insurance be paid at the time of treatment.

**Initial Visit:**  All new patients referred to our office will be scheduled for a comprehensive oral examination with Dr.Jenkins. Dental x-rays may be required in order to provide an accurate diagnosis. We request that you contact the referring dentist to have any recent full mouth x-rays sent to our office. Our fee for your initial exam is $148 and a full mouth set of x-rays is $137.50

**Insurance:**  We are in-network providers for all Delta PPO & Delta Premier, HealthPartners, Metlife & the insurance plans contracted with the Premier network. It is the patients responsibility to be aware of his/her insurance benefits, exclusions and frequency limitations. Every plan is different and changes do occur frequently. We will submit a treatment plan to your insurance company after your appointment with Dr.Jenkins. This is done to provide you with an estimate of your co-pay prior to your treatment. If you are covered by 2 insurance companies, you need to be aware of a duplication clause and verify whether or not your secondary insurance has standard coordination of benefits or not. This may limit your secondary insurance payment.

**Private Pay Patients:**  Full payment is due at the time of your treatment for individuals not carrying any dental insurance.

**I have read and understand this financial policy. I have been given the opportunity to ask questions regarding this policy.**

**Patient Name: (print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_**