David B. Killian, DMD, P.C.
305 South Hanover Street
Carlisle, PA 17013
(717) 243-8888

OUR FINANCIAL POLICY

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 our fees, Financial Policy, or your responsibility.

- **PAYMENT OF OFFICE VISIT IS DUE AT THE TIME OF SERVICE** unless you are instructed otherwise by the secretary after you have seen the doctor.

- **WE ACCEPT CASH, CHECKS, VISA/MASTERCARD**

REGARDING INSURANCE

If you have insurance, we will help you receive maximum benefits. An insurance claim will only be completed if we are furnished full insurance company information. Otherwise, you are responsible for payment at time of service.

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We will inform you if we are a party to your insurance contract, and will handle your claims according to our agreement with the insurance company. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc., other than to supply factual information as necessary. **YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.**

If an appointment is cancelled with less than 24 hours notice, or the patient misses their appointment, the office of David B. Killian, DMD, P.C. will charge an additional $50.00 cancellation fee.

I agree that if I do not comply with the provisions set forth regarding the payment policy of this office, and Dr. Killian refers this account to its collection agency and/or attorneys for collection efforts, I will also be responsible for and agree to reimburse Dr. David B. Killian, DMD, P.C. for any and all reasonable collection fees, legal fees, filing fees, service costs and disbursements incurred as a result of the collection effort.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

Responsible Party Signature _____ **Date** _____