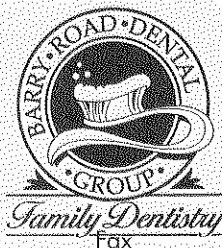


Stephanie Altenburg, D.D.S.
Tim Altenburg, D.D.S.



The Practice of
Family Dentistry

5571 N.W. Barry Road • Kansas City, MO 64154

816-587-0600 Office • 816-587-7662

PAYMENT POLICY

Welcome to Barry Road Dental Group. We are very excited about your visit(s) with us. To help ensure your visit(s) goes as smoothly as possible we would like to give you an overview of our financial practices.

1. Payment is expected at the time of service. Methods of payment in our office include: Cash, Check, Visa, MasterCard and Discover credit cards. Financing is also available through Care Credit; please see our receptionist for more details about this program.
2. If you have insurance benefits please make sure the receptionist has a copy of your card. We will gladly contact your insurance carrier for you to verify your benefits, co-payments, deductibles and your yearly maximum, however, it is your responsibility to understand your dental plan and your plan's individual limitations and any exclusion your employer may have. Denial of a payment by your insurance company for any reason will leave the balance your responsibility.
3. We will ESTIMATE to the best of our ability your portion of the balance due when services are rendered based on the information provided by your insurance company.
4. If your insurance company has not paid the FULL BALANCE on your claim within 45 days of the date of service, you are required to pay for the services rendered. Past due accounts COULD BE TURNED OVER TO A COLLECTION AGENCY AND REPORTED TO THE CREDIT BUREAU.
5. The undersigned agrees to be responsible for payment of all services rendered. Additionally, in the event it is necessary to pursue legal action to collect the patient's account balance, the undersigned agrees to pay for any legal expenses including our reasonable collection fees and/or attorney fees.
6. A \$50 fee will be applied to your account for any returned check.
7. We understand that your time is valuable to you as well as to us. As a courtesy, if you must reschedule or cancel we do ask our patients to notify us at least 24 hrs. prior to your appointment. Failure to do so will result in a \$50 charge.
8. Please understand if you are the parent bringing your child to our office for dental care you are legally responsible for payments of all charges.
9. I authorize and request my insurance company to pay directly to the dentists or dental group, insurance benefits otherwise payable to me.
10. I authorize the dental group to release my information including, diagnosis and the records of any treatments or examinations rendered to me or my child during the period of such dental care, to third party payors and/or other health care practitioners.

Signature

Date