

BRADLEY N. ADKINS, DDS, PLLC  
2319 GRACE AVE.

NEW BERN, NC 28562



**ADKINS**  
DENTISTRY  
— DDS, PLLC —

## Financial Policy

### **Payment is due at the time of service.**

The following methods of payment are acceptable:

1. Cash, Check or Credit Card (VISA, MasterCard, American Express, or CareCredit)
2. Dental Insurance (described below).
3. Third-party financing may be available in our office via CareCredit.

### Related Financial Policies:

1. **5% Discount for Cash or Check payment for all services over \$300.**
2. **Returned Checks:** There will be a \$30 handling fee for any returned check, and loss of 5% cash discount.
3. **Balances older than 30 days** may be subject to additional collection fees and interest charges of 1.5% per month or 18% annually. These additional fees will be applied to an unpaid balance on your account.
4. **Past Due Accounts:** In the event that the account is not paid in full after 90 days and we refer the account to collection, you will be responsible for all fees incurred for the collection of your bill (ie. Attorney fees, court costs and collection/legal fee of 50%).
5. **Broken Appointments:** We understand emergencies or unforeseen events may arise, but your appointment time has been reserved exclusively for you. **Kindly provide a minimum of 48 hours notice for appointment rescheduling or cancellation.** If insufficient notice is given, a \$25 broken appointment fee may be charged to your account. A pattern of late cancellations or no show appointments will limit scheduling options or may lead to dismissal from this practice.

### Dental Insurance:

1. As a courtesy to you, we will file your insurance electronically and accept assignment of benefit. We require that you pay your estimated co-payment and deductible at the time of service.
2. Your insurance contract is between you, your employer, and the insurance company. Our dental office is not responsible for knowing your dental benefits. Dental insurance is not intended to relieve the patient of financial responsibility. Dental insurance is designed to assist the patient and any inconvenience it may cause is the responsibility of the patient.
3. Not all services are a covered benefit in all contracts. This is your responsibility to know and understand your dental benefits prior to your appointment. You are responsible for the charges that insurance does not pay.
4. Please note that claims that are not paid by the insurance company within **60 days** will be the patient's responsibility to pay.

**I have read and understand the above financial policies. I understand that I am responsible (regardless of my insurance) for any charges incurred for services rendered.**

Signature \_\_\_\_\_  
(Patient, legal guardian or authorized agent of patient)

Date \_\_\_\_\_

### **Insurance Assignment of Benefits (if you plan to utilize dental insurance):**

I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Bradley Adkins. I have read and understand the above insurance information.

Signature \_\_\_\_\_

Date \_\_\_\_\_