Julie Corbin, DDS
690 Cooper Foster Park Road
Lorain, OH 44053
440-282-2023

FINANCIAL POLICY

In an effort to be as helpful as possible with paying for your dental care, we have developed this financial policy.

Our office policy is as follows:

1. We accept payment by CASH, CHECK, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS

2. As a courtesy, we will accept most insurance, and will gladly process your claim, however any estimated deductibles, and co-payments will be due in full at the time of visit. The estimates we provide are based on your insurance at that time. Your insurance company has a final say over how much they deem to be your responsibility and how much they will pay. Although our office will process your insurance claims, please understand that it is your responsibility to satisfy any account balances in full for all services rendered. When claim processing is complete, if there is a credit on your account we ask that you notify our office if you would prefer the credit not to remain on your account.

3. We offer financing through Care Credit for more extensive dental work.

4. All payment is required as outlined in the financial policy. If Julie Corbin DDS LLC incurs any expenses in collecting or attempting to collect money due as a result of the patient's failure to make payments as due, all such expenses will be charged to the customer's account. These expenses include, but are not limited to collection costs and attorney's fees.

5. **For separated or divorced parents:**
   The parent who brings the child to the office is responsible for payment of fees charged for that child's care, per our office policy. If another agrees to be payment responsibility, that person must provide a notarized acknowledgment in writing of their desire to pay for care. Payment will be due at the time of the child's appointment. The person bringing the child to the office is responsible for obtaining a written agreement and to inform the other person of care being provided. Your understanding and cooperation with this matter is greatly appreciated.

If you have any questions regarding these financial policies, please do not hesitate to speak to our office personnel.

PLEASE ACKNOWLEDGE THAT YOU UNDERSTAND THE ABOVE POLICIES.

Date _____

Patient or Responsible Party signature_____