Shayegan Shamsaie, DDS
812-385-5272
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Financial Policy

306 N. Prince St.
Princeton, IN 47670

This is an agreement between Shayegan Shamsaie, D.D.S., as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Shayegan Shamsaie, D.D.S.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge or re-billing fee, if any, and any payments or credits applied to your account during the month.

Late Fees: A monthly re-billing fee of $5 or a 1.25% Finance Charge (15% APR), whichever is greater, may be imposed on each account that is over thirty (30) days past-due. We determine your account is past-due by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred up to 35%. If suit must be filed, you agree to pay all lawyers fees incurred plus all court costs. In case of suit, you agree the venue shall be in Gibson County, Indiana, unless suit is filed by our third party collections agency, in which case the venue is of the agency's choosing.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Required payments: Any co-payments required by an out of network insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Payment options if you have NO insurance:

1. You may choose to pay by __cash, __check, or __credit card on the day that treatment is rendered.
2. On treatment involving laboratory fees (crowns, bridges, dentures, etc.) you may choose to pay 50% on the preparation date and the remaining balance in three weeks.
3. On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.
4. We offer special payment plans through Care Credit. Some plans may be interest free, ask for more details.

Payment options if you have insurance:

1. You may choose to pay your deductible of $_____ and any out-of-pocket portions at the time services are rendered by __cash, __check, or __credit card.
2. You may choose to pay all of your treatment by __cash, __check, or __credit card. We will request your insurance carrier send their payment directly to you.
3. On extensive treatment (crowns or bridges) you may choose to pay 50% of your out-of-pocket portion on the start or preparation date, and the remaining balance on the completion or delivery date three weeks later.

   For visits under $200, payment is expected at the time of service, regardless of insurance. We will request your insurance carrier send their payment directly to you.

The Financial Policy continues on the back side of this page.

By signing below, I acknowledge that I have read this Financial Policy in entirety, and I agree to all of the terms and conditions outlined.

Patient's Name: _____

Responsible Party (If not the patient): _____

Signature: _____ **Date:** _____

Co-Signature: _____ **Date:** _____

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Divorce: Inc case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is other parents' responsibility to collect from the other parent.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Missed appointment fee: Patients who do not show up on time for an appointment, or cancel with less than 24 hours notice will be charged a $20 fee. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

Returned checks: There is a $25 fee for any checks returned by the bank.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. We cannot bill your attorney for charges incurred due to a personal injury case.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect absence of insurance, other financial arrangements.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.