Lake Cumberland
ENDODONTICS

OUR FINANCIAL POLICY

OFFICE OF SHEA CHEAVRONT, DMD
87 SARAH'S LANE
SOMERSET, KY 42503

Welcome to our office, we are happy to have the opportunity to serve you. Our goal is to provide the finest endodontic care at the most reasonable price. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must complete our information and insurance form before seeing the doctor.

- **Full payment is due at the time of service.**
- **We accept cash, checks, or all major credit cards.**
- **We offer extended, interest free, payment plans with Care Credit**

INSURANCE

If you have dental insurance, it is the policy of our office to collect 50% of the treatment fee at the time the service is delivered. We will file a claim for your outstanding balance as a courtesy to you. You will need to bring ALL necessary updated information with you to your appointment. If you fail to bring this information, we will be unable to file your claim.

Your insurance claim will be filed upon completion of treatment. If your insurance company has not paid your account in full within 60 days, the balance becomes your responsibility. Insurance companies rarely pay 100% of the charges incurred. Most carriers pay 50% to 80% of their allowable fees up to a yearly maximum of $1000 to $1500 subject to a deductible. You will be responsible for any amount not covered by your insurance and we will refund any overpayment from the insurance company to you.

We are not a preferred provider for your insurance, and are not party to the contract; therefore, questions about your policy should be directed to your insurance company, not to our office.

I have read the Financial Policy. I understand and agree to the Financial Policy.

Signature: _____ **Date:** _____

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment. I hereby authorize payment, directly to the above-named dentist of the group benefits otherwise payable to me.

Signature: _____ **Date:** _____

Thank you for understanding our finacnial policy.
Please let us know if you have any questions or concerns.

OFFICE HOURS: MONDAY - THURSDAY 8AM - 4PM **CALL US:** 606-679-3010