Financial Policy

Oceans Dental PC
(402) 423-9053
7555 S. 57th St. Suite 4
Lincoln, NE 68516

This is an agreement between Oceans Dental PC and the Patient named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient. 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 Oceans Dental PC.

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, a late penalty, if any, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days.

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.

Payment if you have no insurance: Payment in full is due on the date of service unless other arrangements are approved by us.

Payment if you have insurance: Payment in full is due within 30 days of your statement date unless other arrangements are approved by us.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. It is the insurance company that makes the final determination of your eligibility.

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.

Late Penalty: Unless other arrangements have been made with our billing department, accounts over thirty (30) days past due will be subject to a late penalty of $5.00 per month on the unpaid balance.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. Severely negligent accounts may be referred to a collection agency.

Returned checks: There is a fee (currently $25) for any checks 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.

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.

Patient's name:____

Responsible party (if not the patient): ______________________________

Signature:________________________ Date: __________________