Edwards & Cavendish P.A.

General and Cosmetic Dentistry
137 West Adams Street
Jacksonville, Florida 32202

Welcome to our office. We are happy that you have chosen us for your dental needs, and we will do our best to make your experience a pleasant one.

As with most professional offices, full payment for services is expected at each visit. We accept:

Cash
Check Discover
Visa/ Mastercard

REGARDING INSURANCE

We will gladly discuss your proposed treatment plan and answer any questions relating to your insurance. Please realize, however, that:

1) Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.

2) Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each company. This applies only to companies who pay a percentage (such as 50% or 80%) of the "UCR". "UCR" is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in our area.

3) Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover. We must emphasize that as medical and dental care providers, our relationship is with you, not your insurance company. **WHILE FILING OF INSURANCE IS A COURTESY THAT WE EXTEND TO OUR PATIENTS, ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE THE SERVICES ARE RENDERED.**

4) We may accept assignment of insurance benefits for your procedure if the anticipated charge exceeds $300.00. If we agree to accept assignment of benefits for your dental treatment, we will require your estimated co-payment at the time of the procedure and will await payment of the balance from the insurance company. If the insurance company fails to pay all or part of the anticipated benefit, or if payment has not been received within 45 days, you are responsible for the entire balance. We agree to await assignment of

benefits from insurance carriers as a courtesy to our patients. However, please understand that **YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY, AND YOU ARE ULTIMATELY RESPONSIBLE FOR THE ENTIRE FEE SHOULD THE COMPANY FAIL TO PAY.**

MINOR PATIENTS

The parent or guardian accompanying a minor is responsible for full payment, regardless of any child custody and/ or medical payment responsibility by the other parent. NO CHILD UNDER THE AGE OF 18 WILL BE TREATED WITHOUT A PARENT OR LEGAL GUARDIAN PRESENT.

COLLECTION POLICY

A service charge will be added to all deficiency balances over 45 days. You will also be liable for any reasonable attorney and/ or collection fees and all related costs necessary to remit the balance back to this office.

I hereby certify that I have read the above financial policy, understand its contents fully, and agree to comply with the terms as stated above.

X_____ _____

Signature of Responsible Party Date

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/ or dental benefits to which I am entitled, including private medical insurance and any other health plan, to ROBIN FORD EDWARDS, DDS and/ or MICHELE L. CAVENDISH, DMD. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as an original. I understand that I am responsible for all charges, whether or not paid by said insurance. I authorize said assignee to release all information necessary to secure payment.

X_____ _____

Signature of Insured Date