



Our Office Financial Policy

Thank you for choosing us as your dental health provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment. All patients must complete our information and insurance forms before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS CREDIT CARDS, AND DEBIT CARDS. WE ALSO OFFER CARE CREDIT WHICH IS AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Regarding Insurance

We request that any co-payments, deductibles, and any services not covered by your insurance plan be paid at the time the service is provided. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information at your initial visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. Please be aware some possibly all of the services provided may be non-covered services and not considered *reasonable, usual, and customary* under the terms of your dental and/or medical policy.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients

Adult patients are responsible for full payment at time of service. If you are unable to pay at this time, be sure to point this out when you arrive for your appointment.

Minor Patients

The adult accompanying the minor and/or the parents (or guardians) are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at time of service has been verified.

Payment Plans

Our office has partnered with Care Credit, a patient financing company, to offer our patients 0% interest financing for 6 or 12 months with approval. No other payment plans are available.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit (\$30). Please understand that missed appointment times are valuable to those patients that may find it hard to come to the dentist at other times. Please help us serve you better by keeping your scheduled appointments. Excessive cancellations and no shows will result in termination of our agreement and your records can be forwarded to another dental office for a \$10 fee.

Billing

All accounts which have not paid the estimated portion of their bill at the time of service will incur a \$3.00 billing charge each month until the balance is paid. Balances which are 60 days old or older will incur a monthly 1.5% finance charge which equals an 18% per annum rate. There is also a \$30 returned check fee.

Refunds

Refunds for overpayment will be sent after all treatment is completed and insurance has been collected.

Collections

Any account that has not received payment in 60 days will be handed over to a collection agency that will pursue the responsible party for reimbursement. This will negatively impact your credit history and limit the treatment you can receive at our office.

ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere.

I have thoroughly read the Financial Policy and have received a copy. By signing below, I hereby acknowledge that I understand and agree to this Financial Policy.

X _____
Patient Signature or Parent/Guardian of Minor

DATE: _____