Thank you for choosing our office as your dental health care provider. We are committed to the success of your treatment. Part of the commitment is your understanding and responsibility for the payment of your account balance.

FINANCIAL POLICY

PATIENTS PORTION OF ACCOUNT PAYMENT IS DUE AT THE TIME OF SERVICE!

We accept CASH, CHECK, MONEY ORDER, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS! We offer special financing through CARE CREDIT for those patients who need extended payment options. Please note that all payment arrangements must be finalized before treatment begins.

Please note that the adult, parent, or legal guardian who is accompanying a minor is responsible for patient's portion of the payment at the time of service. If the minor is to come to the appointment alone they must bring the payment with them to be presented at the time of service.

INSURANCE

Your insurance policy is a contract between you and your insurance company; We are not a party to that contract. Please be aware that some and perhaps all of the services provided may not be covered services. You are ultimately responsible for the entire balance no matter what the outcome is with your insurance provider.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, we are proud of our fees, which are considered usual and customary for our local area. Parents/Guardians are responsible for full payment for services rendered regardless of any insurance company's arbitrary determination of usual & customary rates. As a courtesy to our patients, we file all standard documentation to your insurance company to assist in acquiring the maximum benefits available for our patients under their contracted insurance plan.

PATIENTS RESPONSIBILITY AND ADDITIONAL TERMS

For non insurance patients, delinquent accounts over 90 days from date of service are subject to a late fee of $30.00 and the account will be forwarded to a collection agency.

For patients with insurance, after we have received your insurance's payment towards services rendered, delinquent accounts over 90 days from the date of the first bill you receive from our office will be subject to a $30.00 late fee and the account will be sent to a collection agency.

Please note that additional charges may be incurred by the patient including court costs and reasonable attorney's fees.

MISSED APPOINTMENTS

We require 24 hour cancellation notice in advance of any scheduled appointments. A NON-REFUNDABLE fee of $50.00 will be applied to your account for any no call, no show, and missed appointments.

We would be happy to discuss any questions or concerns you have regarding this financial policy. Thank you for your understanding and cooperation.

I have read, understand, and agree to all the terms of the financial policy stated above.

X_________________________________

Signature of patient or parent of a minor

X_________________________________ _____/_____/____

Print patients first and last name here Date

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