

Financial Policy

Thank you for trusting us to provide your dental care. Our staff is committed to providing you with the best quality dental care while making your visit a comfortable experience. As part of our service, we try to minimize the cost of dental care. In an effort to do this we have implemented the following Financial Policy. Please read and sign this policy prior to any services.

Payment Policy

FULL PAYMENT IS DUE AT TIME OF SERVICES. **We accept Cash, Check, Credit Cards** (Visa, MasterCard, Discover), and **Debit Cards**. If you have any questions about our fees for our services, please do not hesitate to ask before the service is provided. Your complete satisfaction of our services is very important to us!

Adult patients are responsible for full payment at time of services. Adults accompanying minor patients are responsible for the full payment at time of services for the minor.

Insurance Policy

You are responsible for payment of the estimated balance not covered by your insurance company at the time of services. Please be aware that your insurance company may not cover some services and be aware that your insurance company may pay less than the estimated amount for the services. We can provide you only an estimate of what your insurance company will pay for the services. If your insurance company pays less than the estimated amount for the services, you are responsible for the remaining balance at that time.

We require that you provide a credit card number or have a payment plan authorized before services are provided in the event your insurance company does not pay within **60 days** of the date of services or the insurance company pays less than the estimated amount for the services. In either of these events, your credit card will be charged or your pre-authorized payment plan will become effective for the remaining account balance.

The total balance is your responsibility whether your insurance does or does not pay. Your insurance policy is a contract between yourself and the insurance company. We are not a party to that contract and are not responsible for the amount your insurance company pays for our services. We must rely on our patients to understand their insurance coverage. The insurance payment estimates we provide are only estimates. We have no control over what your insurance company decides to pay for the services. Please make sure to provide us with all your insurance information so that we may assist in getting your claims paid promptly.

Usual and Customary Rates

Our practice is committed to providing the best treatment and quality service for our patients. Fees are set accordingly and are usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Appointment Cancellation

24-hour advance notice is required for appointment cancellation. A **thirty-dollar (\$30.00)** fee will be charged to your account for missed appointments without a 24-hour notice unless an emergency occurs. Please help us serve you better by keeping your scheduled appointments.

Finance and Billing Charges

A **twenty-five dollar (\$25.00)** service fee will be charged for returned checks. Any charges incurred to collect payments on delinquent accounts will be added to the account balance and billed to the responsible party on that account.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read and do understand this Financial Policy.

X _____ **Date:** _____
Signature of Patient/Responsible Party