

OUR FINANCIAL POLICY

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete all forms before seeing the doctor.

**WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS,
PAYPAL AND CARE CREDIT**

INSURANCE AND PATIENT BILLING

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid in full within 60 days, the balance may be transferred to your account. All insurance co-payments and deductibles must be paid at time of service. Your complete insurance information must be presented at the time services are provided.

If your insurance company requires pre-authorization prior to dental procedures, please notify the front office when scheduling your appointment. Full payment for non-covered services is due at the time of the appointment. As well, if you are uninsured, full payment is due at the time of the appointment. If full payment cannot be made, you can apply for Care Credit, or set-up payment plans with the front desk. Payment Plans require 25% due at time of service. We are happy to discuss our charges and how they relate to your particular situation. We realize temporary financial situations may affect timely payment of your account. If such problems do arise, please contact us promptly.

We reserve the right to bill **\$25** for missed appointments or no-shows.

Checks that are returned to our office from your financial institution are subject to a **\$35.00 returned check fee**. This covers the processing fees that are charged to our office.

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 private insurance company's arbitrary determination of usual and customary rates.

If a payment scheduled has not been arranged, interest of 1.5 percent per month will be charged to unpaid monthly balances beyond 60 days.

Any balance over 90 days that has not had a payment made and is not part of a payment plan will be forwarded to a collection agency. Please be advised, if your account is placed for collection, there will be additional attorney fees and court costs.

Signature of Patient or Responsible Party
Date

Written Name