Financial Policy

Thank you for choosing our practice for your oral needs. We are committed to providing you with the best possible care. If you have dental insurance, we are always available to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. Please ask if you have any questions about our financial policy or your responsibility.

- Payment for your treatment is expected on the day service is rendered. We offer the following payment methods: CASH, CHECK, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS. We also offer assistance and accept payment plans through CareCredit financing, which approves health care loans at little or no interest. **INITIAL REQUIRED** _____

  If you have insurance, we will perform insurance estimates and bill the company as a courtesy. You will be responsible for your co-payments and your estimated patient portion at the time of service. If for any reason your insurance company denies any charges or does not cover the amount estimated, the responsibility for payment returns to you.

  If for any reason we over-collect on your patient portion, we will refund you once your insurance company has paid on your claim. If you pay be credit or debit card, we will credit the funds to your card. If you pay with an alternate payment method, we will issue a check to you for the refund.

- Your appointment times are especially reserved for you. In the event that you need to reschedule, please give us the courtesy of a 24 hour business day notice. Failure to notify us at least 24 business hours in advance will result in a cancellation fee of $50 per half hour of appointment time reserved for you. **INITIAL REQUIRED** _____

- Minors, patients under the age of 18, must be accompanied by a parent or legal guardian at the time of treatment unless written treatment consent and pre-approved payment has been received.

- In the event that your account would need to be assigned to an outside collection agency, a 35% collection fee of the balance may be added to the account prior to the assignment. **INITIAL REQUIRED** _____

Consent for Care

I grant permission to the doctor and staff to perform treatment as may be professionally deemed necessary or advisable, including x-rays and photographs that may be needed for diagnostic aids. I agree to the use of anesthetic, sedatives, and other medications as necessary, and understand that using anesthetic agents embodies certain risks, and can ask for a complete recital of any possible complications.

We must emphasize that as a dental care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are **your responsibility** from the day the services are rendered.

I have read the financial policy and consent for care. I understand and agree to these guidelines and consent.

_____ _____

Patient Name (Printed) Patient/Parent/Guardian Signature

_____ _____

Doctor's Signature Date

_____

Witness' Signature