Our Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered 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.

FULL PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED
WE ACCEPT CASH, CHECKS & CREDIT CARDS

Regarding Indemnity Insurance
We may accept assignment of benefits. The balance is your responsibility whether your insurance pays or not. We cannot bill your insurance company unless you give us your insurance information and an original claim form. Your insurance policy is a contract between you and your insurance company. In the event we do not accept your insurance we require that you be pre approved on our extended payment plan or provide a credit card with authorization to bill the unpaid balance.

Regarding insurance plans where we are a participating dental office, all co pays and deductibles are due at the time of service. In the event that your insurance coverage changes to a plan where we are not participating please refer to the above paragraph.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we change what is usual and customary for our area. You are responsible for your payment regardless of any insurance company arbitrary determination of usual and customary rates.

- Patients under the age of 18 must be accompanied by a parent or legal guardian and are responsible for full payment of the child.

Missed and Cancelled Appointments
We must be notified 24 hours in advance of all cancellations. Other wise there will be a $25 charge per every 15 minutes you are scheduled. Please understand that we do not double book and the time you are scheduled for can not always be filled we do encourage you to keep the appointment scheduled.

Interest
We do reserve the right to charge an interest of 5% for any outstanding bill greater than 30 days.

If your account becomes delinquent and is referred to collections you will be billed for any and all collection fees.

Thank you for understanding our financial policy. Please let us know if there are any questions or concerns. Please sign below this states that you have read and fully understand the agreement.

Name:_____ Date:_____

Name:_____ Date:_____