Financial Policy

Patient Name

Responsible Party

Relation to Patient

We are privileged you have chosen us as your dental care provider. We are committed to providing you and your family with quality patient care. The following is a statement of our Financial Policy which you need to understand prior to treatment. If you have any questions. please ask before signing.

Full payment is due at the time of service. We accept cash, checks, and most major credit cards. There will be a $35.00 fee on all returned checks. We reserve the right to charge for appointments canceled or broken without 24 hours advance notice.

Regarding insurance: Your insurance policy is a contract between you and your insurance company. We have no control over their decisions and the amount they decide to pay. However. as a courtesy to our patients. we will file your primary insurance claims for you.

Before treatment. we will verify your coverage and calculate your deductible and copayments as accurately as possible. All treatment plans given are only an estimate based on the information your insurance company provides. All deductibles and copayments are due the day the treatment is rendered. Please be aware that your insurance company does not guarantee payment over the phone. We will not know the exact amount they will pay until they respond to the claim.

REGARDLESS OF WHAT YOUR INSURANCE COMPANY PAYS, YOU ARE FULLY RESPONSIBLE FOR PAYMENT OF YOUR BILL. Once a payment is received on your claim. we will send you a statement of any remaining balance on your account.

At our discretion. any unpaid balance after 90 days will be sent to collections at which the patient is responsible for any fees associated with the collection for the balance.

I have read and understand the above Financial Policy. By signing below, I acknowledge responsibility and agree to the terms above.

Signature

Date