FINANCIAL POLICY

Thank you for choosing us for your dental needs. We are committed to providing you with excellent dental care, and payment of your bill is part of successful treatment. Our financial policy is based on an open and honest discussion of our fees.

PAYMENT IN FULL IS DUE AT TIME OF SERVICE.

We offer several options of payment for the treatment we provide.

- We accept cash, checks, Visa, Mastercard, Discover and American Express.
- Upon credit approval we offer interest free payment plans for up to one year thru Care Credit

USUAL AND CUSTOMARY RATES

We are committed to providing excellent dental care to all of our patients. Our fees reflect our commitment to the quality our patients deserve and are usual and customary for this area, regardless of any insurance company's determination.

INSURANCE

As a service to our patients we will bill your insurance company provided you bring a current dental insurance card, otherwise payment in full is due at the time of service. A 20%-50% co-pay will be expected at the time of service depending on your coverage. Any treatment/service that is not a benefit of your insurance plan is your responsibility. ***Your dental insurance is a contract between you and your insurance company.*** **As a health care provider we are not party to that agreement but we will help you to maximize your benefits and we are available to answer your questions.**

MISSED APPOINTMENTS

Be advised that the policy of this office is to charge for missed appointments unless they are canceled **24** hours in advance. **The charge is a minimum $50.00 and is not covered by your insurance company**. Once an appointment has been made, please remember this time has been reserved specifically for you.

SERVICE CHARGES

The policy of this office is to charge 18%APR interest on all outstanding accounts past 90 days. We charge a $25.00 fee for returned checks. In the event that an account is turned over to for a collection process, the patient will be liable for any additional fees including but not limited to attorney's fees and court costs.

FINANCIAL CONSENT

The patient (or guardian) agrees to be fully responsible for total payment of treatment performed in the office. I also understand that it is my responsibility to keep my doctors' office informed of any changes in my insurance coverage, my address, name and phone numbers. I accept responsibility for payment in full if I fail to provide this information in a timely manner.

_____ _____

Patient Signature Date