OUR FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to improve your dental well-being. Please understand that payment for your services is a part of your responsibility for a healthy smile. The following is our Financial Policy that we require you read and sign prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE
WE ACCEPT CASH, CHECKS, VISA, MASTERCARD AND AMERICAN EXPRESS
WE OFFER A PAYMENT PLAN WITH PRIOR CREDIT APPROVAL

Regarding Insurance:
We accept assignment of insurance benefits to be as helpful as possible. Dental insurance is intended to only be an aid and rarely covers 100% of the total cost of your dental care. We do require estimated patient portion of the bill to be paid at the time services are rendered. Every plan has its own provisions, which we must abide by. Certain costs will be passed along to the patient, such as deductibles, co-payments and co-insurance amounts. It is important that you provide us with correct and current insurance information. As a patient, you have a certain responsibilities: (1) to pay amount not covered by your insurance carrier (2) to be knowledgeable about your plan's covered and non covered services (3) to notify us if there are any changes in your coverage. The balance is your responsibility whether your insurance company pays or not. If your insurance company has not paid your account in full within 45 days, the balance is immediately due and payable by you. Please contact your insurance company if insurance payment is not received in a timely manner, since this is your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered reasonable and necessary by your insurance company. Monthly statements are sent to you until the balance is paid in full. We will do our best to work within your plan to help you receive maximum benefits.
If it becomes necessary to send your account to a collection agency or attorney; you will be responsible for all costs, interest, and attorney fees. There is a $35.00 fee for all returned checks for whatever reason, thereafter, we reserve the right for all future payments to be paid in cash or money order. For all patient balances over 30 days, there will be a financial charge, cumulative per month, on unpaid monies due to the practice.

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

NON-COVERED SERVICES ARE CHARGED OUR USUAL AND CUSTOMARY FEES,
REGARDLESS OF INSURANCE COMPANY POLICY PER STATE LAW

Minor Patients:
The adult accompanying a minor and the parent (guardian of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized by a Visa, MasterCard, American Express, or payment by cash or check at the time services have been rendered.

Missed Appointments: We reserve the right to charge a $40.00 no-show/cancellation fee for any office related visits and procedures. In consideration of other patient, please notify our office of cancellations within 48 hours so we may accommodate another patient to be seen at that scheduled time.

Thank you for understanding. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

X_____ _____
Signature of Patient or Responsible Party Date