FINANCIAL POLICY

We are committed to providing our patients with the best care possible. This agreement provides a written statement of our policies and procedures. Please let us know if you have any questions. We are happy to address any questions or concerns.

DENTAL INSURANCE: Your insurance policy is a contract between you and your insurance company. As health care providers, we are not a party to that agreement. We want to emphasize that our relationship is with you, not your dental benefit provider. There are not guarantees of dental insurance benefits. If your insurance does not cover all or part of the treatment provided, you will be responsible for payment of fees which are not reimbursed by your insurance. We are committed to helping our patients maximize their benefits and will work with you to achieve the maximum benefits for your coverage. If you have dental insurance, we will complete and submit a claim form to your benefit provider as a courtesy to you.

PAYMENTS: Payment in full is due at the time of service. If you have dental insurance, your estimated co-payment is due at the time of service. We accept cash, checks, bank debit cards, Visa, MasterCard and American Express.

TREATMENT PLAN ESTIMATE: Once we have assessed your dental condition, we will present you with a treatment plan and provide you with an estimate of both your insurance benefits and your co-payments. Please note that the dental benefits are subject to various limits as determined by your benefit provider. All co-payments are due at the time of service.

LATE FEES: Should your account exceed sixty (60) days, one and one half (1.5%) interest per month (18% per year) will be charged. In the event your account exceeds ninety (90) days after all insurance claims have been paid, your account will be sent to a collection agency and/or small claims court and an additional $85 fee will be charged for administrative fees. In the event of incurred costs for your default of payment, you agree to be responsible for all attorneys' fees and other court costs associated with enforcing this agreement.

RETURNED CHECKS: Written checks that are returned for any reason are subject to a "return check charge" of $35. 00. In the even that a check is returned, we will require a cashier's check as payment for the original balance in addition to the returned check charge.

CANCELLED APPOINTMENTS: As a courtesy to our patients, we will remind our patients of their appointments by telephone. Once an appointment has been made, this scheduled time has been reserved for you. We understand circumstances arise that may prevent you from making your scheduled appointment. However, please note that should you fail to show for your appointment or fail to cancel your scheduled appointment within twenty four (24) hours of the scheduled appointment time, you may be subject to a charge of $50.00

I have reviewed the above terms and agree to be fully responsible for payment of treatment provided by this office. Further, I authorize this office to file claims to my insurance carrier on my behalf.

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Print Name

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Patient or Parent/ Guardian Signature ***Date***