Our Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality of care. Please understand that payment of your bill is considered part of your treatment.

Payment is due at the time of service unless prior financial arrangements are made. Our office accepts cash, personal checks, MasterCard, Visa and Discover in addition to prepayment discounts. Outside financing is available upon request and approval.

NSF Checks: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistant; you will be responsible for any collection and/or legal charges incurred up to 35%.

Interest Charged: An interest charge of 1.5% (18% annual percentage rate) will be applied to all accounts with or without insurance that is not paid in full after 60 days from the time services was rendered.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company the day services are rendered.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Missed Appointments: Once an appointment is made it is reserved specifically for you so we do ask in advance that you please give us the courtesy of at least 48 hours notice for any appointment change requests. We reserve the right to charge a fee of $125.00 to any cancellation or change request that does not fall within that timeframe.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

CONSENT:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office.

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

When restorative treatment is completed in our office, we offer a three-year warranty. We will replace or redo your restorative treatment **providing** you come in for your hygiene recall appointments and complete all recommended treatment.

Patient Signature (Parent of Child)_____Date_____