

Financial/ Appointment Policy

We value you as a patient and are committed to providing you with the best possible dental care. We want you to have a complete understanding of your financial responsibilities for the services to be provided. To assist us in achieving these goals, we ask that you review our financial policy.

Unless payment arrangements have been approved in advance by our authorized staff, payment in full will be due at time services are rendered. We will be happy to help process your claim for reimbursement or you may assign your primary insurance benefits to the doctor as partial payment toward the services rendered. This can be done after we have had the opportunity to verify your primary insurance benefits.

At the time of your appointment, you will be expected to pay your deductible as well as any portion of the treatment fee that we estimate will not be covered by your insurance policy. Because of insurance policy changes and/or necessary changes in treatment plans, your dental coverage may vary from this estimated treatment calculation or your carrier's pre-estimate. **If your insurance company has not paid the full balance of the claim within 45 days from the treatment date, you will be responsible for paying the balance.**

Please remember that your insurance is a contract between you and your insurance company and/or employer. Our dental practice is not a party to the contract. We recommend that any questions regarding the amount of coverage for the specific treatment be discussed directly with your insurance company or your employer.

A finance charge of 1.5% per month and a statement fee may be assessed to accounts with balances outstanding for 60 days from treatment date. This FINANCE CHARGE represents an ANNUAL RATE of 18%.

If your check is dishonored or returned for any reason, you expressly authorize our office to electronically debit your bank account for the amount of the check, plus \$30.00 processing fee. Your use of a check for payment is your acceptance of this agreement and its terms.

All treatment charges are the responsibility of the patient or responsible party regardless of insurance coverage. In the event of non-payment, the patient or responsible party agrees to pay all costs of the collection including but not limited to attorney fees, court costs, collection agency fees, etc.

Once an appointment has been made, please remember this time has been specifically reserved for you. Due to the high patient volume, it is our policy that upon three missed or failed scheduled appointments, we reserve the right to discontinue treatment to you as a patient.

I have read and understand the financial policy and missed/broken appointment policy of this practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of Patient/Parent/Guardian _____ Date _____