FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. The following is our financial policy. Our main concern is that you receive the proper and optimal treatments needed to improve and maintain your oral health. Therefore, if you have any questions or concerns about or payment policies please do not hesitate to ask our office staff.
Payment for services is due at the time of service & will be collected from the privacy of the operatory. We accept cash, checks, and for your convenience: Visa, MasterCard, Discover and Care Credit. We will be happy to process your insurance claims. But be aware that you may have co-pays and deductibles to meet.

In special instances, we may accept assignment of insurance benefits. However, understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility, whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Fees for these services along with unpaid deductibles and co-payments are due at the time of service. We estimate these payments for you given all the information we have available. Any information you can provide us will help to estimate more accurately.
4. If the insurance company does not pay your balance in full within 30 days we may ask that you contact your carrier to help speed things up.
5. If the insurance company does not pay in full within 45 days we may ask you to pay your balance in full with cash, check or credit card.
6. If responsible party does not contact the office to amend an account that is not in "good-standing" before 90 days after services were rendered we will be forced to send account to collections.
7. Returned checks will be charged a service charge in addition to balance. After checks returned, checks will no longer be accepted for payment. Balances older than 60 days may be subject to additional collection fees and will be charged finance charges of 1 1/2 % per month.
8. Fees quoted are good for a 6 month time period, and may change after 6 months from date of quote.
9. Parents that accompany minor children ARE responsible for the charges incurred.
10. Pre-booking fees are required for appointments that are 2+ hours. If appointment is kept this fee will be applied to your copay, if this appointment is failed without 24 hour's notice or late to a point where treatment cannot be completed pre-booking fee is non-refundable.
11. Any refunds needed are paid out only by check cut by a private party accountant and can take up to 2 weeks for processing.

The fee for *all appointments* cancelled without at least *24 hours* notice is *$1 for each minute* of the scheduled appointment. Please give us the courtesy to offer your appointment time to another patient on the waiting list.
When possible give us as much notice as possible when an appointment needs to be cancelled.

We understand that temporary financial problems may affect the timely payment of your balance. We encourage you to communicate any such problems so we can assist you in the management of your account.

Print Patient Name: _____ Date: _____

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Responsible Party's Signature: _____ Date: _____