Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our information and insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. WE ACCEPT CASH, CHECKS, or VISA/MASTERCARD AND DISCOVER.

Regarding Insurance _______

Your dental insurance is just that: **your** dental insurance. Please try to find out as much about your coverage as you can through your company's personnel department or by calling your insurance company directly. We are familiar with most dental plans so please don't hesitate to ask our receptionist, if you have questions. A majority of dental plans require co-payment and/or a yearly deductible from the patient. This co-payment should be paid when services are rendered.

We will gladly submit dental claims to your insurance on your behalf. Most of the time we can now send claims electronically to help expedite payment for you. Although we take pride in our efforts to optimally utilize your dental insurance benefits, any uncovered dental charges remain the responsibility of the patient**. Our relationship is with you, not your insurance company**.

Usual and Customary Rates _______

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 payments regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients _______

Adult patients are responsible for full payment at time of service, unless prior arrangements have been made.

Minor Patients _______

The adult accompanying a minor and/or the parents/guardians of the minor are responsible for full payment. For unaccompanied minors non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit card, (i.e. Visa, MasterCard or Discover) or payment is made by cash or check at time of service unless prior arrangements have been made.

Missed Appointments _______

If you are unable to keep an appointment time or need to make a change, we ask that you give us reasonable notice by calling us 48 hours in advance. We try as a courtesy to call a day or two before to remind you of your appointment. **Ultimately it is your responsibility to keep your reserved appointment time**. A charge of ***$55*** per hour may be made after 3 broken or failed appointments without reasonable notice.

Financial Considerations _______

We require payment for services on the day they are performed unless arrangements have been previously made. This policy enables us to minimize our bookkeeping and postage cost, and helps us keep our fees fair and as low as possible. For extensive services like crowns, bridges, and dentures, you are entitled to a detailed treatment plan before you begin.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

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

____ Date ________________

Signature of patient or responsible party

____ Date ________________

Signature of co-responsible party