Our Financial Policy

Thank you for choosing us as your dental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. We are happy to bill your insurance as a courtesy to you; however, any balance that is not covered under your insurance plan is patient responsibility. **If you do not have insurance coverage please ask us about our Patient Loyalty Program.**

**********PAYMENT IS DUE AT TIME OF SERVICE**********

We accept cash, checks, Visa, American Express, Mastercard & Discover. We also offer extended payment plans through Care Credit. If you do not have insurance, we offer a *5%* discount if your patient portion is paid in full prior to the day of service. The *5%* discount does not apply to sedation appointments.

INSURANCE

We may accept assignment of insurance benefits, but your co-pay and deductible is to be paid at the time of service. The remaining balance is your responsibility whether your insurance company pays or not. We do not render services based on the assumption that our charges will be paid by your insurance company. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. If your insurance company has not paid your account in full within 45 days the balance will automatically be billed directly to you. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your dental plan. It will be your responsibility to know your policy; we will do our best to help you obtain any information needed. **ALL CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.**

USUAL AND CUSTOMARY FEES

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.

MINOR PATIENTS

The parent or guardian accompanying the minor is responsible for full payment. For unaccompanied minors, nonemergency treatment will be denied unless completely covered by insurance or charges have been paid prior to treatment. In case of divorce, please do not place our office in the middle of marital disputes. It is your responsibility to work out decisions and payment of your child's dental care between custodial and non-custodial agreements.

MISSED/CANCELLED APPOINTMENTS

We value your time and ask that you value ours. **If you are unable to keep a scheduled appointment or arrive more than 10 minutes late, your appointment will be rescheduled and a $25 (per hour) charge will be applied to your account. If you are unable to keep a scheduled appointment, we require at least a 48 hour notice in order to reschedule with no fees. Missing three or more appointments can result in dismissal from the practice.**

OUTSTANDING BALANCES

It is our intention to eliminate billing all together. There will be some instances that are unavoidable. All outstanding balances that are over 90 days will be subject to a finance charge of *18%* annual.

FEE ESTIMATES

Any estimate quoted on a printed treatment plan for dental care can only be extended for a period of 30 days from the date of the patient's estimate. We will do our best to estimate your patient portion if you have insurance, anything that is remaining is your responsibility.

CONSENT FOR SERVICES

In consideration for the professional services rendered to me by the Doctor or at my request, I agree to pay therefore the value of said services to the Doctor or his assignee at the time services are rendered. I understand that all charges are ultimately my responsibility even if I have dental insurance coverage. I understand that should I breach this policy my account will be turned over to collections and I agree to pay all costs and attorney fees.

Signature of Patient/Responsible Party: _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____