About Our Office

Thank you for choosing us as your dental provider. We are committed to providing you with the best possible care. If you have dental insurance, we are here to help you to receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

Initial Visit. Payment in full is required at the time of your initial appointment. We will be happy to help you file your insurance so that you may be properly reimbursed.

Payment Options. Our financial policy was designed to give you a number of payment options to choose from in order to make your payment as easy on you as we can. We accept cash, check, credit cards (Visa, MasterCard, Discover or American Express) or pre-approved extended payment plans. **Payment is due at the time services are rendered unless prior financial arrangements have been made.**

Insurance Payment. At the time of service, you will be required to pay the difference between the total amount due less the amount that is **estimated** that your insurance will cover. We will gladly file your insurance as a courtesy to you. If an insurance claim has not been paid within 45 days, we require that you pay the balance using one of our approved payment options.

Please understand that you are responsible for the balance due on your account as a result of any and all professional services rendered by the office. Regardless of your insurance status. **Please note, while we try to get the maximum benefits for you, we are out of network for insurance.**

Cancellations, Late, or Missed Appointments. Please provide **48 hours** advance notification if you are unable to keep your appointment. Failure to do so **may** result in a cancellation fee of $55.00 per hour. Unfortunately if you arrive more than 15 minutes late, we cannot guarantee treatment will be provided.

Services Charges. For those patients with an unpaid balance over 60-days, we may add a 1.5% per month service charge onto the balance. I understand on past due accounts, I will pay all collection costs incurred, in an amount not to exceed fifty percent (50%) of the unpaid balance, should any unpaid balance be referred to a collection agency. In addition, should any unpaid balance due be referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid for by the undersigned as allowed by the Court.

Miscellaneous Fees. There will be a $25.00 fee for a check that is returned for any reason. Fees are also charged for services such as copy of medical records or narrative report by the Doctor.

No work will be completed unless balance is paid full.

We realize that temporary financial problems may affect timely payments of your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account.

I AGREE THAT A CREDIT EVALUATION MAY BE OBTAINED TO DETERMINE FINANCIAL ARRANGEMENTS FOR THIS ACCOUNT

Thank you for trusting us with your dental care. If you have any questions regarding our policies or payment options, please contact our Office Manager.

I HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISIONS OF THIS POLICY

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Signature of Patient or Person Financially Responsible for Payment on Account **Date**