Financial Policy

Welcome! Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our Financial Policy. If you have any questions after reviewing our policy, please ask the receptionist.

Insurance: If you have dental insurance, we will gladly file your claim for you; however, you are responsible for your account. Insurance companies do not guarantee payment based on the information that they provide us. You are ultimately responsible for knowing your benefits, however as a courtesy each patient will receive an estimate for treatment needed, which will include estimated co-pays and deductibles. **This is only an estimate** and any amount that is not covered by your insurance is your financial responsibility.

Cancellation Policy: We reserve the right to charge $50 per hour for all broken/cancelled appointments that do not allow a 48 hour notice or minimum of 24 hour notice.

Saturday Appointments: a credit card is required for all reservations for a Saturday appointments. Any appointment canceled within 24 hours or for which the patient does not show, will be charged a fee of $50.00.

Payments: *Payment is due at the time of service*. For any extensive/ sedation treatment, you will be expected to apply a reservation fee at the time of scheduling. In addition to Cash, Checks, Visa, MasterCard, Discover, and American Express we offer other payment options-please see our financial coordinator for details. If payment is made with a check, and it is returned, you will be responsible for a **$35.00** returned check charge.

As our patient, we ask that you keep your account current to allow us to continue providing our highest level of care for you, your family and friends. If your account balance exceeds 30 days, you will receive a notice informing you that your account is overdue. If your account becomes delinquent (over 90 days), it will be turned over to a local collection agency and you will incur any collection costs and any related attorney's fees.

Patient or Guardian Signature:_____**Date:**___/___/_____

Printed Name of Patient or Guardian:_____