Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment.

Payment is due at the time service is provided. Our office accepts Visa, MasterCard, Discover, American Express, personal checks, and cash. A $35.00 fee will be charged for returned checks.

Insurance:

- As a courtesy, we will file your insurance claims if you provide our office with all of the necessary insurance information. If you cannot provide that information at the time of your visit, you will need to pay for that day's visit in full and we will help you to file your claim when the information is received and direct the payment to you.
- Please inform our office of any changes with your insurance as soon as you arrive to our office for your appointment, before you are taken back for treatment.
- Deductibles and/or co-payments are due at the time of service.
- Insurance estimates are provided as a courtesy, and are not a guarantee of payment. Your insurance company and your plan benefits ultimately determine the amount paid. If for any reason your insurance does not pay or pays less than estimated, you will responsible for the unpaid balance.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We will gladly file your insurance claim for you; however, please be advised that you are ultimately responsible for the balance due to our office. It is your responsibility to follow through with the insurance company if they do not pay. If payment is not received within 60 days, you will be billed the balance. We will gladly refund any overpayment to you if requested or you will have a credit on file for your next visit.

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors:

The parent or guardian who brings the child for their visit is responsible for payment on that day of service, independent of what a divorce decree or custody arrangement may state. Reimbursement must be made between the divorced parents.

Appointment Policy

Your appointment time is reserved specifically for you. If for any reason you must cancel or change your appointment, our office requires at least **24 hours notice** so that time may be offered to someone else.

We will attempt to reach you by using our automated reminder system, reminder card, email, text message or telephone prior to your appointment. We ask that you please reply in some form to let us know you will be making your scheduled appointment. If we have not received confirmation 24 hrs prior to your appointment time, we reserve the right to give your treatment time to another patient.

Appointments missed, cancelled or rescheduled with less than 24 hours notice are considered broken appointments. A **$35.00 fee** will be charged and must be paid prior to rescheduling your appointment. After three broken appointments, we reserve the right to dismiss you as a patient or require a deposit before scheduling future appointments.

Children under the age of 18 must be accompanied by a parent or guardian.

Reminder calls, texts and emails for appointments are a courtesy only. Patients/parents are responsible for remembering their scheduled appointments. It is your responsibility to provide us with a working telephone number and/or email address to allow us to communicate important information, and provide reminders of scheduled appointments.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL POLICY AND APPOINTMENT POLICY.

_____ _____

Signature of Patient or Responsible Party Date