OFFICE FINANCIAL POLICY

Thank you for choosing us as your family's dental health care provider. We are committed to providing your family with ideal treatment. It is our goal for patients to clearly understand their treatment needs and financial responsibilities. The following is a statement of our financial policy which we require you read, agree to, and sign; prior to any treatment. This financial policy applies to all services rendered by the doctor or dental hygienists.

In order to avoid any misunderstandings, we would like to make you aware of our financial policy:

- Due to the high demand for appointments ***a <u>48-hour business day notice</u> is required to cancel any office appointment.*** *This must be done with a member of our staff and not by text, email or answering machine. Failure to give our office 48-hour business day notice may result in a minimum charge of $75.00.*
- Payment is expected in full for each visit.
- We accept payment in cash, check, or credit card (Master Card/Visa/Discover)
- We also offer a financing plan called "***Care Credit".***
- All other financial arrangements must be made in writing.
- There will be a charge for returned checks.

If you have Dental Insurance

It is our policy that the patient, rather than the insurance company, is responsible for the complete payment of our services. Your insurance policy is a contract between you, your employer, and your insurance company. We are not party to that contract. Our relationship is with you, not your insurance company. As a courtesy to our patients, we will accept assignment of insurance benefits. All patients with insurance coverage are responsible for payment of non-covered services, any deductible amount not previously met and any co-payment due, at the time services are rendered. We will bill your insurance when you have supplied us with all of the necessary information required to process your claim.

In order to avoid any misunderstandings, we would like to make you aware of our insurance policy

- If your insurance company has not paid our office within 45 days from the time of service, you will be required to pay the balance in full by one of the payment options stated above. Any balance over 60 days will accrue a 1.5% finance charge and any account past due over 90 days is subject to legal proceedings. All necessary collection charges will be the responsibility of the patient.
- We are **not an HMO provider**. We ask that the patient be aware of their plan and its coverage **prior** to their appointment.
- We are a Delta Dental PPO and Premiere provider but we are considered an **out-of-network** provider with all other insurance companies.
- Our estimate of the insurance coverage is not a guarantee of what the insurance company will pay.

If there are any questions concerning these policies, please ask.

I,_____/_____ have read and understand the financial policy.
Signature **Date**

(Print Name)_____ S.S.#_____-_____-_____

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