

Our Financial Policy

Thank you for choosing us as your children's dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

Insurance Patients

For those patients who are covered by insurance, we will accept assignment of benefits. Most dental insurance plans do not cover 100% of the cost of your treatment. Because of the delay in receiving payment from the insurance company, you will be asked to pay your deductible and your estimated portion of charges the day the service is rendered. We will estimate as closely as possible your coverage, but until we actually receive payment from your insurance, it is an estimate. Your dental insurance is a contract between you and the insurance carrier, and not between the insurance carrier and the dentist. We will assist you in dealing with your insurance company, but the ultimate responsibility lies with you. After 45 days from the original filing payment is expected in full from you.

Non-Insurance Patients

We require full payment at the time services are rendered. We accept cash, checks, VISA, MasterCard, American Express and Discover Card. We will also help you obtain dental financing if desired.

We offer a 5% accounting reduction if you pay by cash/check for the entire treatment plan prior to treatment and a 3% discount if you pay by credit card.

Returned Checks

There will be a \$25.00 handling fee for any returned checks.

Broken Appointments

We have set aside time especially for you and we would appreciate 48 hours notice if you are unable to make your scheduled appointment. This notice allows other patients, who may be waiting or have an emergency, an opportunity to use this available time. In case of broken appointments with less than 48 hours notice an additional fee of \$50.00 will be charged.

If the account becomes past due you will be responsible for the collection cost or attorney fees that may be necessary to collect the past due account. A finance charge of 15% annual percentage rate may be added to all accounts not paid in full within 45 days of completion of treatment or account due date.

I certify that I have read, understand and agree to these financial policies.

Signature of Person Financially Responsible

Date _____

Should the account fall past due greater than 45 days, I authorize that the unpaid balance be charged to my major credit card as listed below:

Card Type

Card Number

Exp. Date

Name as it appears on card

Signature

Date

Name of Patient

