



FINANCIAL POLICY

PATIENTS WITH DENTAL INSURANCE:

Be prepared to pay your estimated portion of the dental fees at the time of service. Once we receive payment from your insurance company, we will send you a statement showing their payment and your remaining balance.

We will bill all insurance companies as a courtesy to you, but our office is not contracted with all insurance companies. We strongly recommend calling your insurance carrier directly to confirm in-network status of our office if this is important to you. We will help you collect the insurance funds that are due to you, however, should they refuse to pay, the balance is your responsibility.

_____(INITIAL)

PATIENTS WITHOUT DENTAL INSURANCE:

Payment in full is due at the time of service. For treatment that requires more than one appointment, you make make two payments, one at each appointment, given that the first payment covers no less than half of the full amount due.

_____(INITIAL)

FINANCIAL POLICY FOR ALL PATIENTS:

If payment is not received in full within 120 days of the date of service, your account will be turned over to our billing agency. A finance charge of \$50 may be added to any account sent to collections and you agree to pay any reasonable costs of collections or attorney fees.

_____(INITIAL)

A \$30 fee will be assessed for returned checks.

If a dental bill continues to go unpaid, further treatment may be refused.

We offer financing with CareCredit with no interest for up to 6 months as well as extended payment plans for those who qualify with Care Credit.

BROKEN APPOINTMENTS

Our office encourages all patients to keep their scheduled appointments. If you must change your appointment, we require a minimum of 48 business hours' notice to avoid a cancellation fee. If we do not have confirmation from you 48 business hours in advance of your appointment via phone, text or email, your appointment may be removed and you will need to call to reschedule. A missed appointment fee will be charged for late cancellations or no shows.

_____(INITIAL)

AFTER HOURS EMERGENCIES

In the event of an emergency after regular business hours or days the office is closed, a \$175 emergency fee will be charged in addition to the necessary treatment fees.

_____(INITIAL)

By signing below, I acknowledge that I agree and accept the financial policy outlined above. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services provided on my behalf or my dependents.

Print Name: _____ Date: _____

Signature _____