Our Financial Policy

Full payment is due at the time of service, unless we are billing your insurance for you, in which case any applicable co-payment or deductible is due at time of service. If payment is not received at time of service, a 10% service charge will be added to your balance. _____ initial

Regarding Insurance

As a courtesy we will bill your benefit plan for the charges which the company has agreed to pay. We appreciate the opportunity to help you maximize any dental benefits you may have. In an effort to do this we will provide a complimentary estimate analysis of any benefits to which you may have access. In order to provide you with the best information we have available from your benefit plan we will need to know about any services provided outside our office. Pre-authorizations are known to change. If your benefit plan has not paid your account within 60 days, the account balance automatically becomes your responsibility and will become due immediately. Please be aware that some of the items or services provided may not be covered or may not be approved for payment under your policy, but have been deemed to be in your best interest by your dentist. Further, if you have received treatment outside of this office that utilized your dental benefits, this preauthorization will not be valid.

Responsibility

Cancellations or failed appointments made with less than two business days' notice will be subject to a $50/hour fee. If a true emergency should arise the policy will be re-evaluated on a case by case basis. _____ initial

If you are 18 years old or older, you are legally responsible for your own account regardless of who you come with, who has a contract with a benefit plan, or who claims you as a tax deduction. If the patient is under 18 years old, both parents, despite divorce or other separating arrangements, or the legal guardian of the patient is responsible for payment.

Any accounts with a balance older than 90 days will be subject to an 18% interest rate.

I have read the Financial Policy and understand and agree to its terms:

_____

Signature of patient or responsible party

Date:_____