



## FINANCIAL POLICY

Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require that you read and sign.

All patients either with or without insurance must provide our office with a valid social security number. If a valid social security number is not obtained, patient will agree to pay in full at time of service with either cash or credit/debit card (no checks). If you have insurance and a valid social security number is not provided the patient will also be responsible for submitting his/her own insurance claims.

Payment / co-payment is due at the time service is provided. Our office accepts cash, personal checks, Discover, Visa, and Mastercard. For charges of \$500 or greater, a 5% courtesy will be extended for full cash or check payment in advance of treatment. Outside financing is available upon request and approval. If you would like more information regarding these financing plans please ask.

As a courtesy to you we will submit all insurance claims to your insurance provider for you. We will provide an estimate of the portion that your insurance will cover. However, it is NOT a guarantee that your insurance will pay exactly as estimated. We will of course, do all we can to make sure our estimate is as accurate as possible. 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. If payment is not received after 60 days or any claim that is denied by your insurance company, you the patient will be responsible for paying the full amount.

Should the fees for professional services not be paid in accordance with the provisions herein finance charges can be applied to all past due amounts at the rate of \$5.00 possibly more, per month. If the account is in default and turned over for collection, reasonable attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due.

All appointments must be verbally confirmed. Our office holds the right to remove any appointment from our schedule that is not verbally confirmed. Some appointments may require a deposit to be scheduled, this deposit can be kept if our office is not given a 48 hour notice if unable to keep the appointment. Returned checks will be subject to a \$25 bank fee. We retain the right to refuse checks as payment.

If you have any questions concerning this policy please ask our staff. I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guarantor, if a Minor & Date

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Print Name of Patient Guarantor, if a Minor