# OUR FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of the treatment. The following is a statement of our financial policy which we require you to read and sign prior to treatment.

***Our policy is as follows:***

- Full payment is due at the time of service and the patient is responsible for **full payment**.
- We accept cash, checks, or Visa/MasterCard.
- We offer an extended payment plan with credit approval.

***Regarding Dental Insurance***

We may accept assignment of insurance benefits for your visit. However, we do require full payment of the deductible and/or your estimated co-payment at time of each service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your full insurance information. Please understand that your insurance policy is a contract between you and your insurance company and reimbursement levels are dependent upon the premiums you pay and the benefits your company negotiates. We are not a party to the contract.

**In the event that we do accept assignment of benefits and your insurance company has not paid within 30 days, you will be responsible for the total amount of your balance. A service charge of 1.25% per month will be assessed for accounts past due. Please be aware that some, and perhaps all of the services provided, may be non-covered and not considered reasonable and necessary by your insurance company. Please be advised that a fee of $18.95 will also be assessed to all accounts that are sent to collections due to non payment.**

***Usual and Customary Fees***

Our practice is committed to providing the best possible dental and oral health care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of "usual and customary fees." Insurance may calculate their usual and customary fees by determining limitations on the extent or nature of treatment or services that may be provided for you.

***Missed Appointments+***

Because time is reserved for you, a fee of **$100.00** will be assessed for a missed appointment not canceled **at least 72 hours in advance**. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We are happy to provide any answers and are committed to making your visit as pleasant and educational as possible.

*I have read, understand, and agree to this Financial Policy.*

_____ _____

Signature of responsible party Date

Whom may we thank for referring you?