



Financial and Cancellation Policy

Thank you for choosing us as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. 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 that you read and sign prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE

We accept cash, checks, most major credit and debit cards. For those with approved credit, we also accept and can arrange financing through Care Credit, which is a fixed payment/reduced APR plan with deferred interest/no interest if paid in full. We provide discounts for treatment paid in full at time of scheduling, see staff for details. **We request that any co-payments, deductibles, and any services not covered by your insurance plan be paid at the time the service is provided.**

Regarding Insurance

Our dental professionals will diagnose and recommend treatment regarding your dental health and personal dental concerns based on their professional judgment. Dental insurance is a benefit designed to help defray the costs of quality dental care, but is not all-inclusive of what an individual may need or desire to obtain optimal dental health for a lifetime and for that reason insurance coverage should not be considered the standard on which you determine what is appropriate for your dental health needs.

Furthermore, Dental Insurance is a contractual agreement between you, your employer and the insurance company. Our office is not part of that contract. We bill your insurance company as a courtesy and collect your estimated portion at the time services are rendered. Although we are able to estimate your portion, we cannot guarantee any out-of-pocket expense. Ultimately, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Our Fees

Our fees are based on the quality materials we use and the time, effort and skill required by our dental professionals in performing your needed treatment. We charge what is the usual and customary for our area.

Past due accounts

After a period of 60 days of non-payment by an insurer, the entire bill becomes the responsibility of the patient. After 90 days of non-payment, we reserve the right to take necessary steps to collect this debt. Checks that are returned to our office from your financial institution are subject to a \$25.00 returned check fee.

Cancellation Policy

We are committed to seeing our patients on time and respecting their time. Late cancellations (less than 24 hours notice) failed appointments, and late arrivals are disruptive to our schedule and other patients. In order to maintain our schedule we request 24 hours notice for cancellations or rescheduling of appointments. In the instance of a late cancellation (less than 24 hours notice) or a failed appointment there may be a **\$55.00 charge**. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

Signed Acknowledgement

I understand that any insurance coverage estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office. I have received, read, and agree to the financial and cancellation policies listed above.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)