FINANCIAL POLICY

Dear Patient:

Thank you for choosing us as your dental health provider. The following is our Financial Policy. Our main concern is that you receive the proper optimal treatments needed to restore dental health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our office manager.

We ask that all patients read and sign our Financial Policy as well as complete our New Patient and Health History Form prior to seeing the doctor or hygienist.

We accept assignment of insurance benefits. However, you must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services will be your responsibility.
3. Returned checks are subject to additional collection fees.
4. Monthly statements will be sent. However, to keep costs down, we encourage payment at the time of service, either by cash, check or credit card.
5. You will be charged a service charge and/or interest at a rate of 1.67% with a minimum of $5.00, if your bill is not paid within 60 days of charge.
6. In the event of collection, you are responsible to pay reasonable attorney's fees and court costs if deemed necessary for purposes of collection.

Please note, that unless cancelled at least 48 hours in advance, you will be charged for missed appointments at the rate of $40.00 per visit. Please call at least 48 hours in advance if you have to reschedule.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing us as your dental health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Patient's Signature: _____ Date: _____