



Financial Policy

In order to provide you with the highest quality dental care on a sound business basis, we provide our patients with estimates of fees. Patient, parent and/or guardian is responsible for the patient portion on the date of service. This is not your insurance company’s responsibility. **We will file necessary claim to your insurance as a courtesy to you.** Our estimate is a guess based on the information provided by the insurance representative. The information given to us is not a guarantee of payment of approval for the treatment recommended by our dentist. All estimates are subject to final approval by your dental insurance plan. Therefore, the amount due is subject to change after final explanation of benefits have been paid. It is your responsibility to call your insurance company if they have not paid your claim within 45 days from the date of service. Any balance beyond 45 days is your responsibility, and interest will be applied to your account at a rate of 1.5% per month. We reserve the right to apply \$20 rebilling fee, \$25.00 late charges toward overdue financial agreements, and all returned checks are subject to a \$25 fee. We have the option to report your balance with us to any credit reporting agency and credit bureau. In the event that your account is turned over to a Collection Agency or attorney, you agree to pay all fees including and not limited to attorney fees, court costs, and collection agency fees. _____ (Initials) I understand the above information

Financial options that we provide at this time:

- *Cash or check on date of service
- *Major credit card (American Express, MasterCard, Visa)
- *5% reduction on patient portion over 500.00 if paid prior to treatment with cash or check only
- *10% Senior Citizen courtesy (age 65 and over)
- *Extended payment plan (based on credit approval)

It is your responsibility to complete treatment and follow recommended maintenance schedule. If the treatment and maintenance plans are not followed and/or appointments are missed, adverse results could affect your dental health. If you do not proceed with your treatment plan in a timely manner, further treatment for the involved teeth, supporting tissues, adjacent and opposing teeth, muscles or joints can be affected. _____(Initials) I understand the above information

Insurance Policy

Importance of patient awareness regarding insurance benefits:

Our office realizes how important insurance benefits are. We ask that you carefully review your policy and/or contact your insurance carrier so you are aware of benefits, frequencies, limitations, and/or restrictions. Please be informed that dental insurance is a contract between you and your insurance company. While our office is pleased to assist you with filing your claims, the primary focus of our office is providing the highest quality of care for you and your family regardless of insurance frequencies, limitations and/or restrictions. Please be aware that your insurance may have a yearly allowance (maximum) and anything over that amount will be your responsibility. If you have two insurance policies, please be aware that our office will provide you with the treatment information that you can file your second insurance. Your insurance mails a copy of an explanation of Benefits (EOBs) to you. Please pay attention to these statements. Check your policy to see if you have a dental deductible, and if your insurance pays at a percentage or by their allowed fee schedule. Please provide us with a copy of your insurance card and benefit booklet (if available) at your first visit or at the time of dental coverage changes. **It is your responsibility to provide us with any future changes in your insurance.** If any dental services have been provided with any other provider within the existing benefit year, please advise us. _____ (Initials) I understand the above information.

Appointment Commitment

Please review the following:
If circumstances occur and it is necessary to change your schedules appointment, we request that you give us at least 24 hours notice. There will be fee of \$45.00/perhalf an hour depending on the length of the missed appointment. _____ (Initials) I understand the above information

I understand and agree to the aforementioned, and I promise to pay any/all remaining balance on my account.

X _____
Signature of patient, parent of guardian

Date: _____