

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care, and convenient financial arrangements are a part of successful, predictable treatment results. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and our patients' financial capabilities. Please read, sign, and return the following:

Payment

Payment in full is due at the time of service unless prior financial arrangements are made.

We offer several payment options:

1. We accept Cash, Checks, Visa, MasterCard, or Discover.
2. We offer pre-payment discounts.
3. We offer monthly payment plans in accordance with the office credit guidelines

Insurance

Our office is committed to helping our patients maximize their benefits. As you may be aware, medical and dental insurance is becoming extremely complex. We are always available to answer your questions, however, your insurance policy is a contract between you and your insurance company and as a medical provider, we are not party to that agreement. Your patient portion must be paid at the time of service. We ask our patients to provide us with complete dental insurance information. As a service to our patients, we will bill insurance companies for services and allow them 45 days to render payment in full. After 60 days you are responsible for the entire balance and it will be due in full. The quality of insurance policies varies greatly; therefore we can estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts.

Minors

Payment for services for the treatment of minors can be made by check, cash, or credit card and is the responsibility of the adult accompanying that minor.

Missed Appointments

Once an appointment has been made, please remember that this time has been reserved specifically for you. We reserve the right to charge a fee for all canceled or missed appointments without a 24-hour notice.

Service Charges

The policy of this office is to charge a 1.5% monthly (18% annual percentage rate) or a billing charge which will be applied to all accounts over 90 days past due. We will charge \$35.00 for returned checks.

Collection Fees

Fees incurred to collect payment will be billed to and payable by the patient's account holder.

Financial Consent

The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.

I understand and agree to this Financial Policy and Agreement.

Signature of patient/responsible party

Date