

AV Dental Office Policy

Thank you for choosing AV Dental for your dental care. It is our mission to provide you with the highest quality of patient care. Please review our financial policy and sign below.

Please notify us of any changes or problems in your or your child's health immediately.

AV Dental requires that the patient portion of payment is due at the time of service.

We calculate your portion based on the most up-to-date information we have by verifying your benefits with your insurance provider, but it is only an estimate. Your specific insurance policy is an agreement between you and your insurance company. **The patient is responsible for any portion of their insurance benefits that are not covered.** We encourage you to discuss any concerns or questions you may have regarding your specific plan with your insurance company.

We accept all major credit cards, personal checks, and cash. To make your dental care affordable, we also offer no-interest payment plans through Care Credit and Chase Health Advance.

We will do our best to contact you prior to your appointment, however, this is a courtesy reminder and you are still responsible for keeping your appointment. **A fee of \$50 is charged for appointments that are missed or cancelled without 48 hour notice.**

To help achieve our standard of excellence in your oral health care we conduct annual oral cancer screenings as part of our regular exam procedure. This may or may not be covered by your insurance policy.

We send out regular statements for any balance that may accrue on your account. **An interest charge of 5% monthly will be applied to any account with a balance showing no payment activity after 90 days of issuance of the first statement.** Though we try to resolve all financial issues as cordially as possibly, continued lack of payment will result in the account being sent to a collection agency for resolution. Please speak with our staff for an explanation of all financial options available.

I understand and agree to comply with the office policy of AV Dental:

Patient or Guardian Signature

Date

Printed Name of Signor