Dale E. Rhodes, DDS
Cosmetic & Restorative Dentistry
6331 Prospect Ave.
Dallas, Texas 75214

OFFICE FINANCIAL POLICY

In an effort to maintain dental fees at a minimum while maintaining a high level of professional care, we have established the following financial policy for our office:

We require pre-payment in full for dental services rendered that are not covered by dental insurance. We accept cash, checks, Visa, Mastercard, Discover and upon request, we can also provide information regarding a financial company (Care Credit) to help assist with the cost of your dental treatment. You may inquire about Care Credit at our front desk.

We will be happy to file any insurance claims electronically as a courtesy to our patients, provided we have your accurate and updated insurance information on file. **Please Note: We allow 60 days for your insurance company to pay your claim. Past due balances or final balances after insurance payments are received, will be your responsibility. By agreeing to this policy, you agree to all such stipulations and charges. A credit card number will be held on file and securely kept in your record.**

Any balance that becomes delinquent may incur a service charge at the rate of 1.5% per month or 18% annually. You acknowledge that you will be responsible for payment of collection fees, attorney fees and court costs and any unpaid or delinquent accounts.

We schedule our appointments to provide each patient with our undivided attention. In order to accomplish this, please be advised that you may be charged for cancellations with less than a 24 hour notice at the rate of $75.00 for examination/hygiene appointments and $150.00 for restorative appointments.

In treatment cases that require our patients to be premedicated or for those who require extensive work, you will be asked to make payment prior to being seated.

We appreciate your confidence in choosing our practice. Please do not hesitate to ask a staff member any questions you might have regarding this policy.

I have read, understand and agree to the Office Financial Policy stated above.

Patient Signature:_________________________________ **Date:**______________