Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at anytime. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

Payment: Payment is due in full at the time services are rendered. We accept cash, personal check, Visa, MasterCard, Discover, and American Express. If payment is not made within thirty days of the office visit, interest of 1.5% per month (18% per year) will be incurred. All balances are due in full within 60 days of service, regardless of insurance company arrangements. Accounts not settled with 60 days will be forwarded to our collection agency. You are responsible for collection costs, interest and reasonable attorney fees.

Insurance: As a courtesy, this office provides a computer generated insurance form upon the completion of each visit.

We must emphasize that as a dental care provider, our relationship is with you, not your insurance company. All charges are your responsibility from the date the service is rendered.

If you have any questions about the above information or any uncertainty, PLEASE do not hesitate to ask us. The staff is here to help you.

I _____ understand and agree to the above office policy.
(Patient's name)

_____ Date: _____
Patient's signature
*Signature must be by patient or guardian if patient is under the age of 18

Witness Signature: _____ Date: _____

Doctor Signature: _____ Date: _____