OUR FINANCIAL POLICY

Thank you for choosing DIXON FAMILY DENTAL, P.C. as your dental care provider. We are committed to providing you with the best possible care. If you have dental insurance, we would like to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our financial policy. Please understand that payment of your bill is considered a part of your treatment. We require that you read and sign the following statement prior to any treatment.

All patients MUST COMPLETE OUR PATIENT REGISTRATION AND HEALTH HISTORY forms before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AND AM-EXPRESS.
THERE IS A $50.00 CHARGE FOR ALL RETURNED CHECKS!

Regarding Insurance:

If you provide us with complete insurance information, we will be happy to process your insurance claim for you. Your insurance policy is a contract between you and your insurance company. IT IS UP TO YOU TO KNOW YOUR BENEFITS. We ARE NOT a party to that contract. In the event that we do accept assignment of benefits, WE REQUIRE THAT YOU PAY YOUR CO-PAYMENTS AND DEDUCTIBLES AT THE TIME SERVICES ARE RENDERED.

We will gladly discuss cost of your proposed treatment and answer any questions that you may have. Please realize that ALL SERVICES are NOT covered benefits in ALL contracts. We must emphasize that as dental care providers, our relationship is with you, not your insurance company. The filing of insurance claims is a courtesy that we extend to all of our patients.

Usual & Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed Appointments:

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $35.00 per missed visit. Please help us serve you better by keeping scheduled appointments on time.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

______________________________ ______________________________

Signature of patient or parent (of minor) Date