Patient Financial Policy

Welcome to our office! We are honored that you have chosen us as your dental care provider and look forward to working with you. Our dental practice team is committed to providing an excellent dental care experience to you and your family and has implemented the financial policies outlined below to assist in that regard. These financial policies are followed by our practice so that we can stay focused on what we do best-providing you with personalized, comprehensive dental care services. Thank you in advance for your cooperation.

1. Payment for all treatment is due at the time services are rendered unless other payment arrangements have been made with our staff in advance.
2. Payment for services may be made by **Cash**, **Check**, **Visa**, **MasterCard**, **Discover**, and **CareCredit**.
3. The practice has arranged special dental care financial programs with a third party financial institution called **CareCredit**. Please ask your doctor or practice administrator for further information regarding this special financial program.
4. Fees quoted for treatment will remain in effect for 90 days and therefore are subject to change without notice. In event clinical conditions warrant a modification in treatment you will be notified of modifications in treatment and associated fees prior to proceeding with the modified treatment.
5. **If you are unable to keep a scheduled appointment we request you inform us 24 hours before the scheduled appointment time. This allows us to give that valuable time to another individual. We reserve the right to change a cancellation fee of $50.00 on a week day and $75.00 on a weekend with any notice less than 24 hours**.
6. If a check provided by you to the practice in payment for services delivered is returned due to insufficient funds or otherwise there will be a $25.00 returned check fee added to the amount due.
7. If services are not paid for at time services are delivered you will be provided a statement for the amount due and will be expected to pay that amount in full promptly following receipt of statement. If the amount due is not paid in full within 30 days of the services are delivered you will be charged interest on the outstanding amount retroactive to the day of service at a rate of 1.5% per month, or 18% annually, and will be subject to a late payment fee of $29.00 ($39.00 for amounts over $1,000.00) for every 30 days or portion thereof the amount due remains unpaid. If amount due is not paid in full within 30 days of the day services are delivered the practice may, among other remedies, refer the collection of the unpaid amounts to a collection agency or collection attorney and, in such case, you will responsible for any and all fees and expenses of the collection agency or collection attorney relating to the collection of unpaid amounts.

If you have dental insurance the practice will work with you to maximize your allowable insurance benefits and will assist you in making necessary filings with your insurance company. It is understood that the practice will diagnose treatment based on your dental health not your insurance coverage. It is further understood that, since your insurance is a contract between you and your insurance company/employer, the practice cannot assume responsibility for coverage or other determinations made by your insurance company and that you will be responsible for timely payment for all treatment received from the practice regardless of your insurance status. Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the financial policy also shall cover your dependent children who are patients of the practice.

X ______________________________

Patient Name (please print):

X ______________________________

Patient Signature

Date: ______________________________