FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD, DISCOVER AND AMERICAN EXPRESS.

REGARDING INDEMNITY INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We cannot bill your insurance company unless you give us your insurance information. The balance is your responsibility whether your insurance company pays or not. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the insurance coverage.

Regarding Insurance Plans where we are a participate as a provider, all co-pays and deductibles are due at time of treatment. In the event that your insurance coverage changes to a plan where we are not participating as a provider, refer to above paragraph.

Usual and Customary Rates

Our practice is committed to providing the best treatment for out 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 canceled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Interest

We reserve the right to charge interest in the amount of __21__% as provide by state law.

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:

X ________________________________ Date ____________________________
Signature of Patient or Responsible Party