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Our Financial Policy

Patient Name_____ Parent/Guardian Name_____

Thank you for choosing us as your health care provider. The following is a statement of our financial policy which we require you to read and sign prior to any treatment.

Full Payment Is Due At Time of Service

We Accept Cash, Credit, Debit Cards (Visa, MasterCard, Discover and American Express) NO PERSONAL CHECKS
We also welcome Care Credit and Citi Health (3rd Party Financing) **INITIALS_____**

Regarding Insurance

Your insurance is a contract between you and the insurance company. We are not a party to that contract. Dental insurance is not meant to be a pay-all option, but meant to be an aid. So please, be aware that some and perhaps all of the services provided under your particular policy may be considered "Non-Covered Benefits" above their "Usual and Customary Fee" or based on a set "Fee Schedule". Your benefits are dependant on how much you or your employer paid for your particular plan. If you have any questions regarding the details of your plan, we ask that you contact you company. Regardless of what insurance pays, the final balance on your account is considered your responsibility. We are happy to assist you in receiving you maximum allowable benefits and require all pertinent insurance information to be given to us so that eligibility and general benefits can be verified. Once confirmed, our office will be able to accept assignment of benefits and bill your insurance company directly as a courtesy to you. Please understand that we cannot predict exactly what your insurance company will pay on a particular procedure or service and only an estimate can be determined of the charges based on the information your insurance company is willing to provide. An annual deductible and any required co-payment on a particular service will have to be collected at time of service, and can only be based the general information released by your insurance company. We will bill your insurance company as services are rendered. Payment is expected within 45 days of that billing. Any services not paid within 45 day wait period will become immediately due in full. Any unpaid accounts 30 days past due will be subject to a $5.00 monthly billing service charge. **INITIALS_____**

Usual and Customary Rates

Our practice is committed to providing the best treatment for out patient and we charge what is usual and customary for our area. You are responsible for any payment regardless of and insurance company's arbitrary determination of usual and customary rates. Dental insurance usually covers Basic dental procedures, complex comprehensive procedures and cosmetics are often times "Non-Covered Services". **INITIALS_____**

Change or Termination Of Insurance

If your insurance coverage changes or is terminated, please notify our office immediately so we can update your information. **INITIALS_____**

Cancellation of Appointment

If for any reason you are unable to keep your appointment, kindly give us **48** hours notice. Without **48** hours notice your account will be charge $75 /hour fee for the time blocked for your treatment after the second cancelled appointment.
INITIALS_____

Duplication of Records

There will be a $35.00 charge for transfer or duplication of records, with signed Record release. **INITIALS_____**

We are committed to providing our patients with the best possible care and our professional recommendations cannot be dictated or limited by insurance coverage.

I have had the opportunity to read this form, ask questions, understand and agree to the terms of the financial policy. I am responsible for payment of dental fees. I agree attorney's fees, collection fees, or any cost that may be incurred to satisfy this obligation.

Signature of patient/legal guardian _____ Date _____