FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. 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 that you read and sign prior to any treatment. All patients must complete our information and insurance forms before seeing the doctor. FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS CREDIT CARDS, AND DEBIT CARDS.

1. **INSURANCE**

We request that any co-payments, deductibles, and any services not covered by your insurance plan be paid at the time the service is provided. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information at your initial visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. Please be aware some and possibly all of the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of your dental and/or medical policy.

2. **PAYMENT PLANS**

We have partnered with Care Credit, a patient financing company, to offer our patients 0% interest financing for 3, 6, or 12 months with approval. No other payment plans are available.

3. **APPOINTMENTS**

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit ($50). Please understand that missed appointment times are valuable to those patients that may find it hard to come to the dentist at other times. Please help us serve you better by keeping your scheduled appointments. Excessive cancellations and no shows will result in termination of our treatment agreement and your records can be forwarded to another dental office. Please note that we do not accept cancellations via our website or email.

4. **BILLING**

All accounts which have not paid the estimated portion of their bill at the time of service will incur a $3.00 billing charge each month until the balance is paid. Balances which are 60 days old or older will incur a monthly 1.5% finance charge with equals an 18% per annum rate. There is also a $30 returned check fee.

5. **REFUNDS**

Refunds for overpayment will be sent after all treatment is completed and insurance has been collected.

6. **COLLECTIONS**

All accounts over 90 days will be notified in writing of the account being transferred to a collection agency. A finance charge is added to a patient's account each month that the bill is not paid. In the event of any costs incurred in the collection of fees (such as agency fees) due under this agreement, the additional cost will be added to the account. In the event your account becomes past due and is referred to an outside collection agency or attorney, you will be responsible for the collection costs (up to 33% of the balance due), along with reasonable attorney fees and court costs incurred.

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

PRINT NAME: _____

SIGNATURE: _____

DATE: _____