FINANCIAL POLICY

Thank you for choosing us for your dental care. It is our goal to provide you with the finest dental treatment. Please understand that our doctors will recommend the treatment that is best for our patients and by all means not allow your treatment to be determined by your insurance limitations. If you have any questions regarding your insurance coverage please contact your insurance company. If you have financial restraints and need to have your treatment modified, please inform us before treatment.
This information will explain how we can help you take care of your financial needs.

Payment Options: Cash ATM/ Debit Visa/Master Card

We collect your estimated portion prior to treatment. Please note, we check eligibilities and benefits as a courtesy for our patients. Your co-pay at the time of treatment is only an **estimate.** It is the **patients' responsibilities** to know their benefits. Remember that your insurance policy is a contract between you and your insurance company and you are responsible for all charges incurred. As a courtesy, we will bill your insurance company for covered charges. We expect insurance payment within 45 days from the date of service. If your insurance has not paid and the account becomes 60 days old, the account may become a cash account and may be due and payable at that time.

X-rays taken are used for the purpose of diagnosis by the doctor. If the patient wishes to have a copy of the x-ray, there will be a $20 charge for each copy.

I understand that regardless of any dental insurance coverage I may have. I am responsible for payment of dental fees. I agree to pay attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

If there is no insurance coverage available, I understand that I am responsible for all charges incurred, at the time of service.

I have read and understand this office financial policy.

Signature_____Date_____