PATIENT FINANCIAL POLICY

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Welcome to our office. We are honored that you have chosen us as your dental healthcare provider. We are committed to providing you with the best care. If you have dental insurance, we will help you receive your maximum allowable benefits. It is also important that you understand that your insurance is a contract between you and your employer. It is imperative that you are aware of your dental coverage and renewal dates. In order for our office to best serve your needs we need your assistance and your understanding of our payment policy.

- We will do our best to provide each patient requiring treatment with a printed treatment plan.
- If you have insurance we will list expected coverage amounts and your co-pay amounts. This is impossible to do without your help. We do not have information regarding your treatment in another office or the amount of benefits used there. We also need to know about changes in your insurance, (new carrier, new coverage, etc.).
- As a courtesy to our patients, we have extended financing available through Care Credit which has a program with up to 12 months interest free. This is made available to support you in having optimal treatment when you need it. Please check if you are interested in this program. ☐ Yes ☐ No
- Payment is due at the time services are rendered. If you have insurance the co-pay is due. If after receiving the insurance payment the patient co-pay is determined by the insurance company to be a different amount (more than expected) the balance will be your responsibility. Balances over 30 days will be subject to a $5.00 monthly billing charge.
- Fees quoted are accepted for 90 days.
- A $25.00 NSF fee will be charged for all returned checks.
- All scheduled appointments are reserved just for you. If unable to keep your appointment, please notify us at least 24 hours in advance. Failure to do so will result in a $50.00 charge per broken appointment. We have the right to release you as a patient after continuously failing to show up for scheduled appointments.

Print Patient Name: _____

Patient Signature: _____ Date: _____

(Parent or Legal Guardian if under the age of 18)