



FINANCIAL POLICY: Our mission is to deliver the best and most comprehensive dental services available to you. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible. Our accountants will no longer allow us to carry over 90-day interest free loans. We now offer the following (5) payment options:

1. Payment in full by cash or check at time of service, (a bookkeeping courtesy of 5% is given).
2. Payment in full by credit card at time of service. We accept MasterCard, VISA or Discover.
3. Automatic monthly billing to your credit card over 3 months.
4. Payment of ½ of your estimated portion at time of service and the remaining balance due at 2nd appointment or delivery appointment.
5. Private patient finance thru CARECREDIT. Apply by: filling out application and submit through our office, online at www.carecredit.com or call 1-800-365-8295.

*A \$30 fee will be issued for any returned checks and the 5% discount will be added back on to the patient's account.

* DENTAL INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND YOUR INSURANCE CARRIER! As a courtesy our office will file, at no cost to you, your insurance claim. Your estimated portion is due at time of service.

*We are willing to wait up to 60 days from date of service for payment from your carrier. After 90 days, unpaid accounts will go to a collections agency and you will be responsible for any fees charged by the agency, court costs and/or attorney fees.

*If your insurance is denied or the estimated amount is not paid by your insurance company, the full balance becomes YOUR RESPONSIBILITY.

*If your insurance company makes payments directly to you, then you will be responsible to pay your bill in full on the day of service.

CANCELLATION AND FAILED APPOINTMENTS POLICY: Due to an increase in demand for appointments and to help better serve our patients we ask of you the following:

1. Please provide a minimum of 24-hours advance notice when requesting a scheduling change. Failure to give adequate notice or multiple cancellations will result in a \$25 fee charged to your account that must be paid prior to rescheduling.
2. A failed appointment (a missed appointment without any notice), will result in a \$40 charge added to your account that must be paid prior to rescheduling.

*We value your busy schedules and strive to see patients at their scheduled appointment times; we ask that you also value our time. By giving us proper notice it allows us to arrange care for our other patients.

Responsible person/Parent/Guardian:

Signature _____ Date _____

Print Name _____