Financial Policy

Financial Policy

Patient First Name: Patient Last Name: Date of Birth:

•FULL PAYMENT IS DUE AT TIME OF SERVICE.

Insurance: Coverage and Co-pays

We provide insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by our team regarding his/her remaining benefit in any such benefit period. For covered services, all co-pays and deductibles must be paid on the day of treatment. Since your insurance company may not cover all costs, we require that you pay any percentage of your balance not paid by your insurance on the day of treatment. For services that are not covered by your insurance, we require that you pay the entire fee the day of your treatment We will attempt to answer any questions we can about your insurance and, to the extent practicable, assist you with insurance billing issues. However, your insurance contract is an agreement between you and your insurance carrier to which we are not a party. In the event that your insurance company does not pay any amounts due for your care, you agree you are financially responsible for such amounts, and that you will pay such amounts due for your care.

Patients Without Insurance

For patients without insurance coverage, you will be responsible for payment on the day of treatment. If you are not able to pay in full, or if your treatment requires several visits, you will be issued an invoice and will be able to discuss payment arrangements with a member of our business office staff.

Cancellation/No Show Policy/Reschedules

Our office requires at least 48 hours advance notice to cancel your appointment. *This does not include Friday-Sunday changes. Office hours are Monday-Thursday 9:00 AM-5:00 PM If you are needing to make changes to your appointment you must notify the office by: Monday Appt: Wednesday before 5pm Tuesday Appt: Thursday before 5pm Wednesday Appt: Monday before 5pm Thursday Appt: Tuesday before 5pm *We reserve the right to charge a reasonable fee ($50), up to the amount normally due for our services, for patients who do not give advance notice to cancel an appointment.

By checking this box I acknowledge the following:

☐ I have read and understood the Cancellation/ No Show and Rescheduling Policy as stated above.

Collections

A charge will be added to your account for any returned checks. You are responsible to pay all costs of collecting, or attempting to collect any debt owed on your account including all attorneys' fees, interest, and late fees.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature:

Sign