# Financial Policy

Thank you for choosing us as your dental health care provider. We look forward to assisting you in attaining optimum oral health.

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 also complete our Patient Information Form as well as your insurance form, if required by your plan, before seeing the doctor.

**Full Payment Is Due At The Time Of Service** unless other financial arrangements have been made in advance. We accept cash, check, Master Card, Visa, and Discover cards. Other financial services are available through Wells Fargo.

A monthly billing fee of 1.5% or $5.00, whichever is greater, will be added to all accounts that remain unpaid after 60 days. If it becomes necessary to use other means for collecting payment, the patient is responsible for any and all costs, fees, and attorney fees incurred.

**Regarding Insurance**

Our office requires that you pay your deductible and co-payment, if applicable, at the time of service. While every effort will be made to maximize your insurance benefits, **the balance is your responsibility, whether your insurance company pays or not.** If your insurance company has not paid your claim within 60 days, the balance will be automatically billed to you. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your policy.

We will file insurance claims for you if you bring all insurance information and a completed insurance claim form, if required by your plan. **Information regarding insurance benefits is the responsibility of the patient.** Estimates given by our office are not a guarantee of benefits. We cannot be held responsible for the benefits paid, or not paid, by your insurance company.

**Emergency Care**

All emergency care patients are expected to remit payment at the end of the appointment.

**Missed Appointments**

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please have the courtesy to give us at least 48 hours notice so that we may help serve other patients wanting treatment.

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

I have read this Financial Policy, and understand and agree to this Financial Policy.

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Print Name

_____ _____

Patient or Responsible Party Date