

# ***FINANCIAL POLICY***

Thank you for choosing our office for your dental care. We are committed to the success of your treatment. The following is a statement of our financial policy that we ask you to read and sign prior to any treatment. **YOUR CO-PAY & DEDUCTABLE ARE DUE IN FULL AT THE TIME OF SERVICE.** To accommodate you, we accept cash, checks, Visa, MasterCard, Discover, and American Express Cards. For extensive treatment plans, we offer extended payment plans with prior credit approval.

## **Regarding Insurance**

We will accept assignment of your insurance benefits. However, we do require your co-payment and deductible to be paid in full at the time of the visit. The balance is your responsibility whether your insurance company pays for your treatment or not. We will gladly process your claims, provided that you give us accurate insurance information. It is your responsibility to inform us of changes in your insurance coverage. Your insurance policy is a contract between you and your insurance company. We are not a party to the contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered reasonable or necessary under your policy. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due at the time the service is provided. We will accept the "allowed amount" as it is stipulated in our contract with the insurance company. However, if a service is not covered, then it is your financial responsibility.

## **Missed Appointments**

**Our policy is to charge for missed appointments.** Please help us serve you and our other patients better by keeping scheduled appointments. Appointments that are missed or changed at the last minute are then unavailable to patients who need appointments. Please consider your schedule carefully when making appointments.

We require a 24 hour notice for a schedule change. If notice not given:

*\*A broken Hygiene visit will result in a \$50.00 charge.*

*\*A broken Doctor visit will result in a \$75.00 charge*

Thank you for taking the time to read and understand our financial policy. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions. Any of our staff members will be glad to review the financial policy with you at any time.

I have read the Financial Policy. I understand and agree to this financial Policy.

Signature of Patient or Responsible party \_\_\_\_\_

Date \_\_\_\_\_