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.

*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.

Credit Card Fee Acknowledgment

To help offset the rising costs of credit card processing, our office has implemented a 2% service fee for payments made using a credit card. This fee is applied only to credit card transactions and does not apply to Debit, check, cash, or HSA/FSA card payments.

Please read and sign below to acknowledge your understanding and consent:

Acknowledgment:

I understand that a 2% credit card processing fee will be added to any payment I choose to make using a credit card. This fee is not greater than the cost incurred by the practice for processing the transaction. I understand that I may avoid this fee by choosing an alternative payment method such as debit, check, cash, or HSA/FSA card.

☐ I understand the 2% credit card fee for applicable transactions.

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

Signature of Patient or Responsible party:_____ Date_____