Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care so that you may attain optimum oral health. The following is a statement of our financial policy which we require that you read, agree to and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard and Visa. Outside financing is available upon request and approval. Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance you will be responsible for any collection and/or legal charges up to 30%.

Insurance

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company by cash, check, MasterCard or Visa.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We bill your dental insurance as a courtesy to you. We will only bill your medical insurance if required by your dental plan.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I have read, understand and agree to the above terms and conditions. I understand that responsibility for payment of dental services provided in this office is mine and are to be paid at the time services are rendered. I further understand that a finance, rebilling, collection charge and/or attorney fee could be added to any overdue balance.

Patient Signature: _____ Date: _____