Financial Policy

Thank you for choosing us as your dental care provider. Please understand that payment of your bill is considered 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.

General:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered.

MISSED APPOINTMENTS:

Appointment times are reserved especially for you. Therefore, if you come in late, the Doctor may request that you reschedule the appointment and you may be charged a rescheduling fee of $75. If for any reason you should need to change your appointment, there will be no charge, provided you give us 48-hour notice. Please help us serve you better by keeping your scheduled appointments.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company.

As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

By signing this Financial Agreement, I understand and agree that you are authorized to check my credit and employment history.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Signature: _____ Date:_____