FINANCIAL POLICY

We are committed to providing you and your dependents with the best possible dental care. Our office does require that you understand and accept our financial policy ***prior to*** the commencement of any dental procedure that takes place in this office. Acceptance of this policy requires you to place your initials in the required boxes and to sign and date the bottom of this form.

***IF YOU DO NOT HAVE DENTAL INSURANCE*,** payment in full is required at the time services are rendered. As an incentive, we offer a 5% discount for service totals that equal or exceed $500. We **do not** extend credit, or offer payment plans, but we **do accept** Care Credit. We accept cash, checks and major credit cards for payment.

(Please initial: ______________)

IF YOU HAVE DENTAL INSURANCE, we will gladly contact your insurance company to obtain general information about your dental policy; however, if you have specific questions regarding specific procedures or if you need an explanation about a denied or partially denied claim you will need to contact the insurance company on your own.

Please understand that your insurance policy is a contract between you, your employer and the insurance company. Not all services are covered under all plans. Some insurance plans require that you follow certain protocol before some procedures take place. It is your responsibility, as a patient, to know and follow this protocol prior to the start of any dental procedure.

Filling an insurance claim is a ***courtesy*** that we extend to our patients. All charges are ultimately your responsibility from the date services are rendered.

(Please initial: ______________)

This office will attempt to to estimate what portion of your charges will not be covered by your dental insurance policy. At the time services are rendered, you will be asked to pay for this estimated portion. We accept cash, checks and major credit cards for payment. If extenuating circumstances require that you be billed for this portion, payment will be required 30 days from the date services were rendered. Returned checks and balances older than 30 days will be subject, ***without exception,*** to additional collection fees and interest charges of
1 1/2% per month (18% annual)

(Please initial: ______________)

We are pleased that you have chosen this office to care for your dental needs. Please do not hesitate to ask at any time if you have questions about the above information. Please sign and date the bottom of this form. We will keep a signed copy in your dental chart. Thank you for your understanding and cooperation in this matter.

I have read the above and agree to the terms of this financial policy. I have been given a signed copy of this agreement.

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(Signature of Patient or Legal Representative) *(Date)*