# FINANCIAL POLICY

**Patient First Name: _____ Patient Last Name: _____**

**Thank you for choosing us as your dental care provider.**

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility, before treatment begins.

****FULL PAYMENT IS DUE AT THE TIME OF SERVICE****

**We offer the following payment options:**

Flexible payment plans of up to 12 months upon approval with Care Credit or Lending Point. Approval must be received prior to treatment date.

Cash, Check, or Visa/MasterCard, American Express.

As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services.

**REGARDING INSURANCE:**

**We require deductible and coinsurance to be paid in full at the time of service.**

Your insurance policy is a contract between you and your insurance company. However, we will automatically bill your insurance company for services rendered as a courtesy to you.

If your insurance company has not paid the total claim within 60 days from the date of your treatment, the balance will automatically be billed to you. Please be aware that we may receive only

a partial amount of what was billed to your insurance company. You will be responsible for amounts the insurance company has determined as ineligible or not covered in full.

If we cannot verify eligibility prior to treatment, you are expected to pay in full at the time of service. We will be glad to submit your insurance form and direct your insurance company to make payment directly to you.

We are happy to offer these choices so that you can select a payment option that best fits your needs. Again, we are pleased to welcome you as a member of our patient family.

**I realize I am financially responsible for all charges incurred, regardless of insurance coverage.** I am aware past due accounts will be subject to a charge of 1.0% per month late fee. I am responsible for all collection costs incurred by the dental office and on a returned check, a fee of $30.00. You are responsible for collection fees, court costs and reasonable attorney fees to collect unpaid accounts.

**USUAL AND CUSTOMARY RATES:**
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. Under the usual and customary rates also includes understanding that some of the procedures are not covered and will not be sent to my dental insurance.

**MISSED APPOINTMENTS:**
Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $50.00 for appointments which reserve up to an hour and $100.00 for appointments over an hour. Please help us serve you better by keeping scheduled appointments.

**Please Read and Acknowledge by checking the box**

I have read and understand the Financial Policy.

**Patient Signature:_____**

**If not the patient - Relationship to the patient: _____**

**Name if not the patient: _____**