**Financial Policy**

It is our goal to provide high quality dental care to all our patients. We want patients to clearly understand their treatment needs, as well as their financial responsibilities before treatment begins. Payment of estimated patient portion is due at the time of treatment. In our continued commitment to make dental care affordable we offer the following payment options.

**Cash, Check or Visa/MasterCard/Amex/Discover**

We offer a 5% courtesy discount for full payment at time of service, for cash patients only.

**Care Credit**

Financing options available administered through Care Credit. Please ask our administrative staff for details and credit applications.

**In Office Discount Dental Plan**

Available for patients without dental insurance. Please ask our administrative staff for details.

**Insurance Plans**

As a courtesy to patients, our office accepts and files insurance claims. Our responsibility is to provide you with treatment options that best meet your needs, not try to match your care with your 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.

We understand insurance guidelines can be difficult to understand, and with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes the final determination once treatment is completed and the claim is submitted. Your insurance is a contract between you and your insurance provider; therefore, all charges are your responsibility. All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. Past due accounts are subject to a 1% monthly interest charge. Any fees incurred by the office in collecting delinquent accounts or returned checks will be charged to the patient, a fee of $35.00. \_\_\_\_\_\_\_\_(initial)

Broken Appointment Policy: Our office requires **48 hours advance notice to change or reschedule an appointment, with exception to individual circumstances**. I understand that I will be **charged $50 per hour scheduled**, **for any missed or broken appointments**. \_\_\_\_\_\_(initial) Chronic missed appointments may minimize your ability to schedule future appointments and you may be placed on a standby list.

**Signature of Patient and/or Legal Guardian** ­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_