Patient's name: _____

FINANCIAL POLICY AND ACKNOWLEDGEMENT

Thank you for choosing us for your dental needs. With a "Vow of Excellence" our primary focus is your dental health. We will work with you in achieving your dental health goals. We strongly believe that our patients deserve to know, up front, our financial policies. These are described below:

Copayment/Patient portion of the treatment fees is due at the beginning of each dental appointment. Initials _____
Complex/multi-appointment services (e.g., crown, bridge, denture or root canal procedures) require payment of 50% of the fee at the time of the start of treatment. The remaining balance for that treatment is due at the beginning of the appointment when the restoration is completed or the appliance (complete denture, partial denture, crown, etc.) is delivered.

Financial arrangements: For your convenience, we accept payments through major credit cards (Visa, Mastercard, Payment Plans such as CareCredit etc.)

For patients with Insurance:
As a courtesy we will file your insurance claim for you. We will guide your insurance carrier to send all payments directly to our office for reimbursement. Most dental insurance benefits are subject to limitations, exclusions, deductibles, copayments and maximum benefit coverage. We will try our best to give you the closest pre-estimates of your treatment, however, if due to some reason your insurance denies payment, you are then responsible for the full cost of the treatment. In goodwill, we will still honor the discounted insurance fees. If you have made an overpayment, you will be reimbursed. ***Our office recommends dental treatment based on medical necessity and not on whether your insurance company will cover a procedure***. ***It is your responsibility to pay any amount not covered by your insurance company regardless of the reason. Initials _____***

Interest Charges: In the event of default of payment or ***after 90 days***, a ***service charge of 1.5 percent per month or 18 percent annually*** will be added to any outstanding balances not paid within 30 days of the current monthly billing statement. All accounts in which effort to pay is not made will be subject to collection proceedings. ***Initials _____***

Collection Charge and Returned Checks: Any account sent to an outside collection agency will be assessed a $50 collection fee. Any check returned for any reason by your bank will be assessed a $35 fee. ***Initials _____***

Missed/Cancelled Appointment Charge: Our office requires a ***24-hour notice*** for any canceled/rescheduled appointments. A fee of $50 may be assessed for canceling/rescheduling an appointment without 24-hour notice. ***Initials _____***

The undersigned certifies that he/she has read and understands the foregoing, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____ _____
Signature of the patient/parent/guardian Date

_____
Printed Name