Financial Policy Form

Thank you for selecting us as your personal dental care team. To promote a long-term mutually satisfying relationship, we would like to explain our office policy regarding treatment, insurance, appointments and fees. PLEASE, read this carefully and ask any questions or bring up any concerns you may have BEFORE treatment is rendered. SUBMISSION TO TREATMENT IMPLIES YOUR CONSENT TO TERMS OF THIS AGREEMENT.

_____Initials **TREATMENT**: You will find our entire staff is dedicated to helping you improve your dental health as quickly as possible. Every effort will be made to make your appointment as comfortable and pleasant as possible. Please feel free to discuss your treatment with the doctor at any time.

_____Initials **INSURANCE**: If this office is able to accept your insurance company's assignment, the patient is still FULLY RESPONSIBLE for the charges for treatment rendered. Your insurance MAY NOT COVER the services or may only PARTIALLY cover them and any ESTIMATE given by this office is considered a GUIDELINE until the final insurance is received and the patient's account is reconciled. The office can make NO GUARANTEE of the actual payment by your insurance company. For services that have been predetermined, the amount the insurance company may pay may be subject to maximums, deductibles, limitations and non-payment due to employment status.

_____Initials **MISSED/ CANCELED APPOINTMENTS**: When we schedule your appointment, the time is reserved exclusively for you. When you fail to notify us of your inability to keep an appointment, another patient in need of dentistry is unable to receive treatment. We request that you give us at least 24 hours notice when you realize that you cannot keep an appointment. When the requested notice is not given, a **$50 fee may be charged**. For those whose schedules make it difficult to effectively plan ahead, we ask that you do not schedule an appointment in advance, but that you call us the day you can come in and we will be happy to see you then provided the time is available.

_____Initials **PAYMENT IS DUE AT THE TIME OF SERVICES**: We accept cash, personal checks, Master card, Discover, American Express and Visa. When insurance applies we may collect any deductible and estimated co-payment at this time.

_____Initials **PROSTHETICS**: Crown, Dentures, Bridges, etc., FAILURE BY MEMBER TO RETURN FOR THE DELIVERY OF THESE ITEMS IS SUBJECT TO DOCTOR TIME AND LAB FEES CHARGES.

_____Initials **SERVICE CHARGES**:

1. **MONTHLY BILLING**: Even though an insurance claim has been filed, you may receive a statement each month if there is a balance due on your account, since you, not the insurance company, are responsible for payment of your account. A $5.00 charge will be applied every month to accounts with balances outstanding 60 days or longer, regardless of outstanding insurance.
2. **RETURNED CHECKS**: There is a $35.00 fee for returned checks. The check must be picked up personally and cash must be paid to cover the check and the fee.
3. **COLLECTION FEES**: Fees incurred to enforce payment required by this agreement will be charged to the patient whose failure to pay, required these fees to be incurred.

Signature: _____ Date: _____
Patient/Parent or Legal Guardian if the patient is a minor.