

# Our Financial Policy

Thank you for choosing us as your dental care provider. As part of our service, we try to contain the ever-rising cost of dental care. We are committed to your treatment being successful and to providing the highest quality dental services at a reasonable fee. Please understand that payment of your bill is considered a part of your treatment.

## Patient / Insurance Information

We ask that a Patient Information and Health History Form be completed or updated before seeing the dentist to ensure proper treatment and billing.

### **~Insured Patients:**

As a courtesy to our patients, we prepare and process all insurance forms. However, if a claim has not been paid within 60 days, we ask that you pay the balance using one of the following methods of payment.

*Please help us **hold down the costs** of dental care **by paying for your portion of services at the time of each visit** which could include copayment, deductible, percentage or non-covered benefits depending on your insurance plan requirements.*

### **~Non-Insured Patients:**

If there is no insurance coverage, full payment is due at time of service or financial arrangements must be made prior to treatment.

## Payment Options

Our financial policy is designed to give you a number of payment options to choose from in order to make your dental care payment as easy as possible. For your convenience, you may choose any of the following **methods of payment**:

- ❖ Cash
- ❖ Personal Check (postdated if necessary)
- ❖ MasterCard, Visa or Discover
- ❖ Debit Card
- ❖ Pre-approved extended payment plan -- short term plans available with no interest

## Minor Patients

The adult accompanying a minor and the parents (or guardian) is responsible for full payment. Parents must be present for all dental care authorization to minors.

## Missed Appointments

Please help us serve you better by keeping scheduled appointments. Kindly notify us at least 24 hours in advance if you must cancel or reschedule an appointment.

## Financial Agreement

I understand that I am financially responsible for all charges incurred by my dependents, or myself whether or not covered by insurance.

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Patient/Responsible Party

Date