FINANCIAL POLICY

Thank you for choosing our practice to serve your dental needs. Please take the time to read the following, initial each section and sign/date the bottom of this form.

_____ Full payment is due at the time of service unless arrangements have been made prior to the tart any treatment.

_____ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a **courtesy** to our patients. However, insurances balances, which are not paid within 60 days, may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_____ Some of your treatment may **not** be covered by your insurance carrier. The cost for such charges will be your responsibility

_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made

_____ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm your appointment may result in a charge for the time reserved. There will be a $40 charge for any appointment canceled without 24 hour notice.

_____ There will be a fee of $30 for any checks returned as Non-Sufficient funds (NSF).

_____ Patient balances that go unpaid for 30days or more may incur one or more of the following charges:
Interest charges of 1.5% per month or 18% APR Collections fees (up to 42% of the full balance) Legal fees for collection services.

____ ________________________
Signature of Patient's parent of legal guardian Date

____ ________________________
Print Name Witness By