FINANCIAL POLICY

This is a statement of our financial policy which we require you to read and sign prior to any treatment.

It is our goal to keep prices as low as possible. If you have Insurance we will file it for you. If you do not have Insurance we accept cash and all major credit/debit cards. We will accept checks only from established patients or if we are able to verify that funds are available.

REGARDING INSURANCE:

YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT. We accept assignment of insurance benefits after you furnish us with your full insurance information and this is verified by your insurance carrier. **Your deductible and patient portion are due at the time of service.** Some of the services provided may be a non-covered service and not considered necessary by your dental carrier. You are responsible for payment of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS:

The adult accompanying a minor patient is responsible for payment in full.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment directly to the dentist named above for the dental service benefits otherwise payable to me. PLEASE INITIAL _____

I UNDERSTAND THAT IF PERFORMED DENTAL SERVICES ARE NOT UNDER CONTRACT WITH MY INSURANCE CARRIER OR I HAVE MET MY CONTRACT LIMITATIONS, I AM RESPONSIBLE FOR THIS FEE. PLEASE INITIAL _____

MISSED APPOINTMENTS:

We ask that you give us 24 hours notice for any canceled appointment. Once 2 scheduled appointments have been missed we will require you to pay for the appointment in advance before we can schedule you another appointment. We reserve the right to deny any future scheduling of appointments due to repeatedly missed, canceled, or late appointments. PLEASE INITIAL _____

UNPAID BALANCES:

If your account becomes past due, we will take necessary steps to collect this debt. I understand that any attorney fees, court costs, and collection fees become my responsibility and will be added to my account, should it become necessary. Returned checks will be subject to a fee of $30 for each time they are returned. Finance charges of 1.5% per month will be imposed on the unpaid balance after your account has gone 30 days past due. PLEASE INITIAL _____

CREDIT HISTORY:

We have the option to check your credit history and to report your account history to any credit reporting agency such as a credit bureau. PLEASE INITIAL_____

I HAVE READ THE FINANCIAL POLICY AND I UNDERSTAND AND AGREE TO THIS POLICY.

X_____ Date _____

Signature of patient or legal guardian if patient is a minor