FINANCIAL POLICIES

Our goal is to help patients reach the highest level of oral health possible so they may enjoy the benefits of a comfortable, functional, and attractive smile.

PAYMENT POLICY

Payment is expected at the time of your dental treatment.

To assist our patients meeting their dental care needs, we offer several payment options:

- ✓ Cash / Personal Check / Money Order
- ✓ Credit Card: We accept Visa, MasterCard and Discover.
- ✓ CareCredit: A line of credit offered through a third-party financing service allows you and your family members dental care needs to be met in a timely manner. Payment to us is received as treatment is delivered. Based on qualification, monthly payments are made by you to CareCredit.

Please contact our business office *prior* to your scheduled appointment to discuss payment options. There will be a $25 return check fee assessed on all returned checks.

DENTAL BENEFIT PLANS (commonly referred to as "Dental Insurance")

***It is your responsibility to be informed about your dental benefit plan's provisions and stipulations*.** Dental insurance coverage is a contract between you, your employer, and the third-party payer (plan carrier.) Our most important duty is to advise you and treat your dental care needs, without regard to what your benefit plan might "allow" or "cover."

We try our best to assist our patients in understanding their recommended treatment, and help in investigating benefit plan coverage - to the extent we are able. However, with hundreds of companies, and different policies within each company, our office cannot know the benefits for each individual. We urge you to inform yourself of your coverage ***prior to any procedures***. Your Human Resource department or your dental benefit carriers are good resources. We are not responsible for your benefit plan's final determinations, changes in policy, or cancellation of coverage.

As a courtesy, we will gladly submit a dental claim for procedures performed at our office on your behalf to your benefit plan carrier using a standard ADA form. For us to provide this service, it is important that you provide accurate and up-to-date information. Please be prepared to present your insurance identification card at each visit. Additional administrative procedures required by your insurance carrier are your responsibility.

Your estimated co-pay amount is due at the time of service. This is an estimate, based on whatever information is known to us. Should your final benefit amount differ from the estimate, a balance may be due (or may be refunded.)

Reminder: Many insurance companies require pre-authorization or even second opinions. It is your responsibility to inform us *prior* to your appointment if a pre-authorization or a second opinion is required.

I have read and understand the above Financial Policy. Please read and initial policy below.

Signed, x____ Date ___________

CANCELLATION POLICY

We understand that at certain times it is necessary to change an appointment time. We require a 2 business days notice to change or cancel a scheduled appointment. A fee of $50.00 per hour may be assessed for a same day cancellation or if you do not show up for your scheduled appointment.

I have read and understand the above Cancellation Policy.

Initial x__________

This financial statement is provided to notify you of our policies as of the date of signature.