

Office/Financial Policy

Welcome to our office and thank you for choosing us as your dental team. The following is an explanation of our office and financial policies. Please take a moment to familiarize yourself with these policies. We request a signature after you have reviewed these policies and prior to starting any treatment with our office. Should you need any clarification, please don't hesitate to call us and we will do our best to answer any questions.

Regarding Insurance

As a courtesy, we will file a claim to your insurance carrier. Please be prepared to provide us with the proper information needed to submit your claim, i.e. Insured's name, ID#, birthdates, policy/group#, Insurance Carrier and address. **Please recognize that you are ultimately responsible for the payment of this account regardless of insurance coverage.** Delayed payment by your insurance carrier is not a valid reason for delayed payment on your account.

Please be prepared to pay your **co-payment** before completion of your treatment. Estimated co-payments are not a guarantee of insurance payment. Depending on the actual insurance benefit, you may be responsible for more or less of the fees. We strongly recommend you have a basic understanding of your policy benefits to avoid any misunderstandings. Annual Insurance maximums must be monitored by the patient and are not the responsibility of this office.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment Options

In our continued commitment to provide you the highest quality dental care available and to have those services comfortably affordable, we are now offering our patients the following payment options:

Cash, Check, Visa, MasterCard, Discover and Care Credit.

In addition we offer a 5% discount on services to our non-insured/cash patients who pay at the time of service and we offer our senior patients (65+) without insurance a 10% discount.

Financing Options

In addition to Care Credit we offer a variety of in house payment plans unique to each situation. Please discuss with our treatment coordinator.

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Finance Charges and Delinquent Accounts

Finance Charges: The Federal Truth in Lending Act (Regulation "Z") makes it necessary for all firms extending credit to define their credit policy. Our office policy is to extend credit to patients with the understanding that all charges are due and payable with thirty (30) days following the date of billing. The office will extend additional time for repayment of accounts for those who need and/or request it.

All accounts not paid within ninety (90) days are considered past due. All past due balances are subject to a finance charge computed by a "Periodic Rate" of 1.5 % per month, which is an annual percentage rate of 18%.

Delinquent accounts turned over to our outside collection agency will require payment of collection costs.

Returned checks are subject to any bank fees we incurred.

Missed Appointments & Emergency Appointments

It is a courtesy of our office to confirm appointments one day in advance. If for any reason you should need to reschedule your appointment, there will be no charge provided you give us a 24 hour notice. Missed or late cancellation appointments will be charge \$40.00 per ½ hour. Charges must be paid prior to scheduling any further appointments in the office

New patients who schedule and fail their initial new patient appointment will not be reappointed in our office.

Emergency Appointments: Every effort will be made to see patients on an emergency basis during regular hours on the day he/she telephones the office. After hour dental emergency treatment will consist of a telephone consultation to determine what treatment is necessary, and all steps will be taken to resolve the emergency. For security reasons, this office will not be opened at night for patients unknown to the doctors or staff.

Office/Financial Policy

I have read this office/financial policy. I understand and agree to the terms described above.

Name of Patient or responsible party (Print)

Signature of Patient or responsibility party

Date