

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being an enjoyable, comfortable experience. Please understand that payment of your bill is considered a part of **your treatment responsibility**. The following is our Financial Policy, which we ask you to read and sign prior to any treatment.

- **FULL PAYMENT IS DUE AT THE TIME OF SERVICE.**
- **WE ACCEPT, CASH, CHECKS, VISA/MASTERCARD/DISCOVER OR AMERICAN EXPRESS**
- **WE OFFER EXTENDED PAYMENT PLAN.**
- **RETURN CHECKS: There will be a \$25.00 handling charge for any returned check.**
- **DEFAULT: After 60 days without payment, the account will be considered in Default. Upon default, the entire balance shall become immediately due and payment including all Attorneys and Collection Fees and Charges.**

Regarding Insurance

Our office understands the value of insurance benefits to our patients. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, we are happy to fill out and file your insurance forms, directing assignment of benefits to you. We will do all we can to assist you in gaining your maximum benefits. We are happy to make other arrangements for you if possible. **Our goal is to assist you and pass on the savings of containing the costs in billing and account collections.**

Regarding Insurance Plans where we only participate with Delta Dental Premier Plan, all co-pays and deductibles are due at the time of treatment. In the event that your insurance coverage changes, please inform us so we may better assist you.

Insurance Authorization –Please sign.

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
Patient or Responsible Party

Usual and Customary Rates

Our practice is committed to providing the highest care at an affordable cost. You will experience our fee’s to be 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.

Minor Patients

The parents, guardians, or the adult accompanying a minor is responsible for full payment at time of service. For unaccompanied minors, arrangements must be made prior to or at the time of service through an approved credit plan, Visa/MasterCard/Discover/ American Express, or payment by cash or check.

Missed Appointments

Unless notice of cancellation is at least 48 hours in advance a failed reserved appointment charge at the rate of a normal office visit will apply. Please help us serve you better by keeping scheduled appointments.

Method of Payment – Please complete.

- Payment in full at each appointment (cash or personal check)
- Payment in full at each appointment (VISA MC Other)
- Card # _____
- Exp Date _____
- I wish to discuss the Dental Office’s Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within 60 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month, which is an annual percentage rate of 18% applied to the last month’s balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs (\$25 collection fee) and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____
(Signature of Patient or Responsible Party)

Date _____