BUTLER HILL FAMILY DENTISTRY
FINANCIAL POLICY

Dental Services

Payment is due in full at the time of most dental treatments. This includes:

hygiene appointments	operative procedures *(filling and buildups)*	
radiographs	oral surgery	consultations

Services Involving Laboratory Procedures and Endodontic Treatment

The following services require payment of one-half of the charges at the time treatment begins. The balance must be paid prior to the completion of the services. This includes:

crowns	bridges	partials	dentures
repair	orthodontic splints	nightguards	root canals

Insurance

Your insurance policy is an agreement between you and your insurance carrier. We will bill your insurance company on your behalf, but if they do not pay within 30 days, you will be responsible for working out payment arrangements with us directly. In order for this office to accept insurance for payment, a completed insurance form must accompany every office visit.

Deductibles

- Payment of your deductible is due on the day services are provided

Co-payment

- Your percentage of the co-payment is due on the day services are provided

Broken Appointments

This office reserves time for your Dental Treatment. Appointments cancelled without 24 hours notice, are subject to a 'broken appointment' fee of $50.00.

Other Charges

We charge 1½% interest per month, 18% APR for any overdue balances. If collection efforts become necessary, you will be charged for collection fees, Attorney fees and court costs.

Credit Card Option

You have the option to authorize us to bill your VISA or Mastercard directly for your charges. If you accept this option, we will send you a statement after services have been performed. You will then have 10 days to review your account before charges are billed to your credit card. You may cancel this option at any time. If you wish to accept this option, provide the following information:

Type of card ☐ VISA ☐ Mastercard

Name on Card ______________________ Please Print

Account Number ______________________ *Expiration Date* ______________

Car Holder Signature ______________________ *Date* ______________

I have read and agreed to the financial policy of Butler Hill Family Dentistry.

______________________ ______________

Signature *Date*