Our Financial Policy

Thank you for choosing us as your dental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

**********PAYMENT IS DUE AT TIME OF SERVICE**********

We Accept Cash, Checks, Visa, American Express, and MasterCard & Discover. We also offer payment plans through Care Credit.
A 5% discount will be given if the balance is paid at the time of service.

INSURANCE

We may accept assignment of insurance benefits, but your co-pay percentage and deductible is to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. This dental office cannot render services on the assumption that our charges will be paid by an insurance company. We will file your insurance claims on your behalf, but it is necessary to have all insurance information and an original claim form if your insurance company requires it. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. If your insurance company has not paid your account in full within 45 days the balance will automatically be billed directly to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under dental insurance plan. It will be your responsibility to know your insurance coverage policy; we will do our best to help you obtain any information needed.

Regarding insurance plans where we are a participating provider; **ALL CO-PAYS AND DEDUCTIBLES ARE DUE AT TIME OF TREATMENT**. In the event that your insurance coverage changes to a plan that we are not a participating provider for, refer to above paragraph.

USUAL AND CUSTOMARY RATES

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.

ADULT PATIENTS

Adult patients are responsible for their estimated percentage of payment at the time of service.

MINOR PATIENTS

The parent or guardian accompanying a minor is responsible for full payment. For unaccompanied minors, non–emergency treatment will be denied unless completely covered by insurance or charges have been paid prior to treatment.

MISSED APPOINTMENTS

Our policy is to charge for missed appointments, or appointments that are cancelled less than a 24 hr notice at the rate of $25.00 per appointment. Please help us serve you better by keeping scheduled appointments.

RETURNED CHECKS

There will be a $25.00 charge added to your account for any returned checks. Returned check amount and the service fee must be paid in cash or by money order.

OUTSTANDING BALANCES

It is our intention to eliminate billing all together. There will be some instances that are unavoidable. All outstanding balances over 30 days will be subject to a finance charge of 18% annual. Any certified mail that must be sent due to an outstanding balance will be an additional charge to you.

FEE ESTIMATES

Any estimate quoted on a printed treatment plan for dental care can only be extended for a period of 30 days from the date of patient's estimate.

CONSENT FOR SERVICES

In consideration for the professional services rendered to me by the Doctor, or at my request, I agree to pay therefore the value of said services to the Doctor, or his assignee, at the time services are rendered. I understand that all charges are ultimately my responsibility even if I have insurance coverage, and after 45 days if my insurance company does not pay I will be billed for the entire balance. I understand that should I breach this policy my account will be turned over to collection and I agree to pay all costs and attorney fees.

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Signature of Patient or Responsible Party Date