Thank you for choosing us as your dental care provider. 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 read and sign prior to treatment. All patients must complete our information form and provide insurance facts before seeing the doctor.

APPLICABLE PAYMENT IS DUE AT THE TIME OF SERVICE

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD and /or CARE CREDIT

Regarding Insurance

We may accept assignment from your insurance benefits. However, it is **your responsibility.**

If your insurance company has not paid in full within 45 days, you are responsible for full payment of your account and have 10 days to remit payment to this office.

Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance.

All co-pays and deductibles are due at the time of treatment.

Usual and Customary Rates

Our practice is committed to providing the best dental 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. Your up front charges may include a 10% allowance for your insurance company's arbitrary adjustment of the fee schedule.

Adult Patients

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

Minor Patients

The adult accompanying a minor and the patients (or guardians of the minor) is responsible for applicable payment.

Missed Appointments

Unless canceled at least **2 business days** in advance, our policy is to charge for missed appointments at the rate of **$75.00** per office visit. Please help us to serve you better by keeping scheduled appointments.

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

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

X_____ Date:_____

X_____ Date:_____