Paulette R. Sanford, D.D.S.

Office Financial Policy

Dear Patients,

Thank you for choosing us for your dental care. We are committed to providing you excellent care and payment of your bill is part of successful treatment. Our Financial Policy is based on an open and honest discussion of our fees.

Please read, sign and return the following:

Payment In Full Is Due At The Time Of Service.

If you have insurance, please be prepared to pay your co-pay at the time of your visit. We accept Cash, Checks, Visa, Master card and Debit Cards. A third-party financial plan option is also available.

Insurance

As a service to our patients, we will bill your Insurance Company if you supply correct Insurance information. Your insurance policy is a contract between you and your Insurance Company. As a health care provider, we are not party to that agreement. Insurance policy coverage varies and some services provided may not be covered. After 60 days of non-payment by your insurance company, finance charges are applied to your account for the entire unpaid balance. Anything you can do to ensure we have accurate information and to respond timely to inquiries or delays by your insurance company will help avoid these charges. Our office is committed to helping our patients maximize their benefits. We are always available to answer any questions you may have.

Pre-payment Policy

Our office is happy to offer a 5 (five) percent discount to our uninsured patients who prepay accepted treatment plans of over $500.00.

Missed Appointments or Last Minute Cancellations

Once an appointment has been made, please remember this time has been reserved specifically for you. This better enables us to give you the service we would like to give you.

Service Charges

It is the policy of this office to charge interest of 1.5% per month (18% ANNUAL PERCENTAGE RATE) which will be applied to all accounts over 60 days past due. We will charge $25.00 returned check fee.

Collection Fees

Fees incurred to collect payment will be billed to, and are payable by the patient.

Financial Consent

The patient (or guardian) agrees to be fully responsible for total payment of treatment performed in this office.

I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY AGREEMENT.

_____ _____

Signature of Patient/ Responsible Party Date

If you have any questions concerning these financial policies, please feel free to ask. Thank you for your cooperation and understanding.

Dr. Paulette R. Sanford, and Staff