FINANCIAL POLICY FORM

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. 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 are required to sign this document and complete all of the necessary forms prior to seeing the doctor.

Regarding Payment

We do accept the following forms of payment: Cash, Check, Visa/MC, Discover and Care Credit®.

Payment for service is due at the time services are rendered unless prior financial arrangements have been made.

If dentures, partial dentures , crown and bridge are to be fabricated by a dental laboratory, the full amount for the applicable service is due at the first appointment. If prior arrangements are made for larger treatment plans , i.e . ... multiple crowns or bridge work a *75%* deposit will be satisfactory at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due on that date. Unaccompanied minors , non-emergency treatment will be denied unless charges have been pre-authorized before the appointment or previous financial arrangements have been made.

Checks that are returned to our office from your financial institution are subject to a $ 35.00 returned check fee.

Regarding Non-Payment after 90 days

If we do not receive payment from either you or your insurance company within 90 days your account will be charged off to our collection agency on, or shortly after, the account has been unresolved for 90 days.

Regarding Insurance

INSURANCE QUOTES ARE ESTIMATES AND MAY CHANGE AT ANY TIME.

Please understand that your insurance policy is a contract between you and your insurance company. and that we are not party to that contract.

In the event we do not accept assignment of benefits and your insurance company has not paid your account in full within 9o days, the balance may be transferred to your

account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Please understand that you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. All insurance co-pays and deductible must be paid at the time of service.

Regarding Cancellations

Because our time is very valuable to us we require 48 hours notice when canceling an appointment. If an appointment is broken without this notice a $25.00 fee will be added to your account. A patient with two missed/cancelled appointments will be required to prepay for their entire appointment if they desire to schedule in advance for any future appointments, subject to forfeiture if they miss their appointment without giving 48 hours notice of a change. 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 .

Signature of Patient or Guardian Date