FINANCIAL POLICY

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

We have found that our patients appreciate knowing exactly what financial responsibilities they will incur. Therefore, we inform our patients about our financial policies before we begin treatment. Knowing this ahead of time allows us all to arrange for the completion of the necessary dental treatment.

Payment types accepted include: **cash or check, credit card (Visa, Mastercard, Discover), and CareCredit.**

DENTAL INSURANCE

I understand that all dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office, as a courtesy, will help prepare my insurance forms to assist in making collection for insurance companies and will credit such collections to my account. However, I understand that should my insurance not allow payment for any reason, I am ultimately responsible for any incurred balance.

Most insurance companies will not cover 100% of all dental expenses. Your portion, not covered by insurance, is due at the time treatment is performed.

Please understand that dental insurance is a contract between the patient and the insurance carrier. The patient is the responsible party regarding dental fees.

Estimates of insurance payments are exactly that- approximation of benefits to be paid be insurance companies.

_________ By initialing, I understand and agree to the Insurance billing policy.

APPOINTMENT BOOKING POLICY

We respect the importance of your time and we work very hard to schedule appointments that accommodate the scheduling needs of all of our patients. Appointments are considered reservations and you will receive a reminder email/text or call prior to this appointment. If we are unable to reach you, we trust that you will keep your reserved appointment. **CHANGES TO APPOINTMENTS REQUIRE 48 HOURS NOTICE TO AVOID THE RESCHEDULING FEE OF $75 PER SCHEDULED HOUR.**

_________ By initialing, I understand and agree to the Appointment Booking policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS REGARDING THE FINANCIAL, INSURANCE, AND APPOINTMENT POLICIES FOR THIS PRACTICE. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Signature: ____ **Date:** __________________