Insurance and Financial Policy

Please initial:

_____Your dental benefits are based upon a contract between you, your employer and your insurance company. **If you have questions regarding your dental benefits, please contact your employer or insurance company directly. Insurance plans are only meant to assist you with the investment in your dental care. They very rarely pay for the total cost of treatment.**

_____We are contracted with a few select insurance companies and we accept all private care insurance plans (plans that do *not* require you to select a dentist from a list or require our office to accept a reduced fee for our services). Each plan is different and they do change. We estimate your insurance coverage based on the most up-to-date information we have, but it is still **only an estimate.**

_____We will bill your insurance as a courtesy. If insurance does not pay within 60 days, we will request that you make payment in full directly to our office. You may then collect the payment due directly from your insurance company. Ultimately, you are responsible for all charges incurred in our office.

_____We do require payment of your estimated portion at the time services are rendered. We accept cash, checks and major credit cards. For larger balances, we offer extended financial options through CareCredit. CareCredit offers same as cash financing, as well as longer term payment plans. Our staff will be happy to assist you with this option.

_____Accounts that become 60 days past due will be charged a $2 monthly billing fee. In the event that your account becomes more than 90 days past due, you will be responsible for all costs associated with collecting the amount due, including but not limited to, mailing fees, small claims court filings, and a $35 Account Recovery Fee.

_____Appointment time is reserved exclusively for you and we strongly encourage all patients to keep their scheduled appointments. If you must change your appointment, we require at least 24 hours' notice. We reserve the right to charge for failed or cancelled appointments without this required notice. A fee of $25 (per hour that we had reserved for you) will be assessed to your account.

Patient/Responsible Party Signature: _____

Print Name:_____ Date: _____