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## FINANCIAL POLICY

**USUAL AND CUSTOMARY FEES:** Our fees are comparable to the usual and customary fees charged by like general dentists in this area. These charges are based on the cost of materials, the use of local ISO-certified labs, as well as the time and skill involved. These fees are not necessarily the same as what your insurance considers "usual and customary."

**INSURANCE:** Your insurance policy is a contract between you and your insurance company, chosen by your employer or yourself. ***We will help in any way we can to file your claim, however if there is no payment from your insurance company within 45 days, you are responsible for the balance in full.*** Any unpaid balances after 60 days will be subject to finance charges equal to 1.5% per month. Balances over 90 days will be subject to collections.

**PAYMENT AT TIME OF SERVICE:** We require deductibles and copays to be paid at time of service. We do our best to provide you with an accurate estimate, but it is only an estimate. Please, be aware that some of the services we provide may not be covered by your dental plan. ***You are responsible for payment regardless of your insurance company's exclusions and fee schedules.***

**PAYMENT OPTIONS:** We offer a 5% cash discount for all uninsured treatment that is paid via cash or check in full prior to or at the time of service. For your convenience in making deductible and/or copay payments, we accept VISA, MasterCard, Discover, and debit cards. Monthly payment plans are offered through an outside institution. Please inquire prior to treatment if a payment plan needs to be arranged. A $25 fee will be charged for any returned checks.

**MISSED APPOINTMENTS:** Our appointments are arranged in such a way as to efficiently utilize patients' time and *lessen* the number of visits necessary to restore optimal dental health. We also respect our patients' busy schedules by adhering to our committed appointment times and we expect the same courtesy from our patients. We require two (2) business days notice to change or cancel an appointment. A fee of $50/hr may be charged to patients that fail to give the required notice.

**PARENTS OF MINORS:** A parent must be present with treatment of a minor (under age 18). ***In the case of split custody, the parent who brings the child to the appointment is required to pay in full for the estimated portion.***

**CONSENT TO TREATMENT:** I understand that upon request I may receive a copy of this form. I authorize treatment by the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for services rendered to me or my family, I agree to pay reasonable attorney's fee or other such costs. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original).

Signature ______________________________________________ Date ______________________