

Financial Policy

In our continued efforts to provide you with the best dental care possible and to provide those services at reasonable rates, we are pleased to offer the following methods of payment:

{ } Cash or Check (5% discount if balance paid at the time of service)

{ } Visa, Mastercard, Discover or Care Credit

{ } Senior Citizen Discount (as a courtesy to anyone 60 years or older we will gladly discount your fee by 5% if balance is paid at time of service)

The balance is your responsibility. We will gladly bill and accept payment from your insurance company. Insurance policies are contracts between you and your insurance company. To avoid any misunderstandings regarding dental insurance, our professional services are charged to you and you are personally responsible for payment of fees. Since many plans do not provide complete coverage we can estimate your benefits and make appropriate arrangements for the balance. All balances to be paid in full within six months. Please provide us with complete and accurate information.

Please advise us of any changes in insurance information at any time, if we receive correct information the claim will be billed correctly.

If we incur expenses in trying to collect from you, such as filing a law suit, you agree to pay any reasonable collection costs including, but not limited to, reasonable attorney fees that may incur.

If you have any questions regarding your account, please call our office.

I have read, understand and agree to the above Financial Policy.

Signed: _____ Date: _____

Patient's Name: _____

Relationship to Patient: _____

Our office reserves the right to charge patients interest (1.5% monthly) on all outstanding balances and may assign the account without notice.