

OFFICE AND FINANCIAL POLICY

Our office is committed to providing you and your family with the best possible dental care. In order to continue to do this, we need your understanding of, and your adherence to, the office and financial policies. Please take the time to read this carefully.

Since the practice depends upon reimbursement from the patients for the costs incurred in their care, **payments is therefore expected at the time services are rendered.** If you have dental insurance, we will accept assignment of your insurance benefits; however, we do require that **your co-payment and deductible be paid in full at the time of your appointment.** Our office will prepare insurance forms or assist in making collections from your dental insurance company. However, all charges are the patient's responsibility. And any balance that is unpaid by the insurance is also the patient responsibility. Although we will be happy to assist you in any way we can, your insurance policy is a contract between you, or your employer, and the insurance company. Thus you and your insurance company should resolve any conflicts involving your dental insurance.

Please be aware that some, or perhaps all, of the services provided may not be covered (or may be considered as an alternate benefit) under the policy your employer has selected. If the service is not covered, the fee becomes your responsibility. Any claim that is unpaid within 45 days of the date of service also is the patient's responsibility. It is our strongest recommendation that you call your insurance company and become familiar with your plan and its benefits. It is also your responsibility to inform us of any changes in your dental insurance prior to the start of treatment.

As appointment time is reserved specially for you, we reserve the right to charge a broken appointment or cancellation fee of \$30 per every half hour with less than 48 hours notice.

Any returned checks will be subject to a \$35 fee.

In the event that your account is sent to a third party for collection, you will be responsible for any fees involved in the collections process, including attorney fees.

We must emphasize that as dental care providers our relationship is with you, not your insurance company. While the filling of insurance claims is a service that we extend to our patients, all charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect the timely payment of your balance. If such a situation arises, we encourage you to contact us promptly for assistance in the management of your account.

By signing below, I attest that I have read and understood the office and financial policy and agree to its terms and conditions.

X _____ Date _____ Relationship _____

Signature of Patient (parent or guardian)