Financial Policy

Thank you for choosing our practice to serve our dental needs.

Please take the time to read the following, initial each section, and sign and date the bottom of this form.

__________ Full payment is due at the time of service unless arrangements have been made Prior to the start of any treatment.

__________ Insurance balances are ultimately the patient's obligation. We will file most Primary insurance at no cost to you as a courtesy. However, insurance balances Which are not paid within 60 days will be billed to you. Please keep your walkout Statements and follow up with your insurance carrier to ensure prompt Payment.

__________ Some of your treatment may **not** be covered by your insurance carrier. The cost For such charges will be your responsibility.

__________ **All treatment will require a deposit of minimum of $20 dollars for basic and major Services, and will be applied to Patient's copay, if patient does not show for Appointment or cancels within 48 hours the deposit will not be returned. All Major treatment may require a deposit of half the estimated amount.**

__________ Patients are asked to confirm their appointments at least 48 hours in advance by Directly contacting our office or by responding to our confirmation contact. Failure to confirm your appointment may result in a charge for the time reserved.

__________ There will be a fee of $30 dollars for any checks returned as Non-sufficient funds

__________ Patient balances that go unpaid for 30 days or more may incur one or more of the Following charges:

Interest charges of 1.5% per month

18% APR collections fees (up to 25% of the full balance)

Legal fees for collection services

___________________________________ ___________________________________

Signature of Patient or Guardian Date

___________________________________ ___________________________________

Print Name Witnessed By