FINANCIAL POLICY

We are committed to providing our patients with the best dental care possible. Included in that commitment is an open dialogue of our fees and financial policies. This agreement provides a written statement of our policies and procedures. Please review the following information. If you have any questions, please discuss this information with the doctor or his representative.

1. Payments. Payment in full is due at the time of service. If you have dental insurance, your estimated co-payment is due at the time of services. **If your insurance does not cover consultation it's your responsibility of $175.00.** For your convenience, we offer payment options in addition to cash and checks including credit card payments. We accept the following credit cards: Visa, MasterCard and bank debit cards.

2. Health Insurance. Your insurance policy is a contract between you and your insurance company. As health care providers, we are not a party to that agreement. We want to emphasize that our relationship is with you, not your dental benefit provider. There are no guarantees of health insurance benefits. **If your insurance does not cover all or part of the treatment provided, you will be responsible for payment of fees which are not reimbursed by insurance.** However, we are committed to helping our patients maximize their benefits and we will work with you to achieve the maximum benefits for your coverage. If you have dental insurance, we will complete and submit a claim form to your benefit provider as a courtesy to you. If you are covered by a plan that gives you a discounted fee schedule, the discounted fee will be charged to your account and recognized by the insurance carrier upon receipt of claim. If your insurance has a preferred provider list and we are not on that list, you may be responsible for additional costs.

3. Treatment Plan Estimate. Once we have assessed your dental condition, we will present you with a written treatment plan. The treatment plan includes a detailed estimate of each procedure's total fee, separated by the expected benefit portion and the patient's obligation. Please note that the dental benefits are subject to various limits as determined by your benefit provider. All co-payments are due at the time of service. The estimate of fees is guaranteed for sixty (60) days. After such time, the fees are subject to change.

4. Late Fees. Should your account exceed sixty (60) days, one and one-half percent (1.5%) interest per month (18% per year) will be charged. In the event your account exceeds ninety (90) days after all insurance claims have been paid, your account will be sent to a collection agency and/or small claims court and an additional $85.00 will be charged for administrative fees. In the event of incurred costs for your default of payment, you agree to be responsible for all attorneys' fees and other court costs associated with enforcing this agreement.

5. Returned Checks. Patients writing checks that are returned for any reason are subject to a "return check charge" of $35.00. In the event that a check is returned, we will require cash or a cashier's check as payment for the original balance in addition to the returned check charge.

6. Cancelled Appointments. As a courtesy to our patients, we will remind our patients of their appointments by telephone. Once an appointment has been made, this scheduled time has been reserved for you. We understand that circumstances arise that may prevent you from making your scheduled appointment. **However, please note that should you fail to show for your appointment or fail to cancel your scheduled appointment within twenty four (24) hours of the scheduled appointment time, you <u>may</u> be subject to a charge of $250.00.**

I have reviewed the above terms and agree to be fully responsible for payment of treatment provided by this office. Further, I authorize this office to file claims to my insurance carrier on my behalf.

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Patient Name

_____ _____

Patient or Parent/Guardian Signature ***Date***