

PATIENT FINANCIAL POLICY

We are committed to providing you with the best possible care! If you have dental insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policy.

1. Payment is due at the time services are rendered unless payment arrangements have been approved in advance by our team. Emergency visits for all new patients must be paid in full.
2. We accept payment for services in cash, check, MasterCard, Visa, American Express, Discover or ATM/Debit Cards.
3. As a courtesy to our patients, we have a contract with Wells Fargo, Invsalign Patient Finance or Dental Fee Plan for financial arrangements available to you in having optimal treatment when you need it. Some plans offer up to 12 months same as cash.
4. If a complimentary appointment is broken or cancelled with less than 2 working days notice the rescheduled appointment will be at regular fees.
5. In order to secure an oral sedation appointment or an appointment over 3 hours, financials must be secured before treatment can be appointed, so you will not have to worry with anything on the day of your treatment.
6. Broken, canceled or rescheduled appointments with less than 2 working days notice will be charge 10% of the total fee of the appointment (emergencies considered).
7. Account balances older that 90 days will be subject to a billing fee of \$20 per month.
8. A \$20.00 NSF fee will be charged for all returned checks.

Insurance

The process of the utilization and quality of insurance has changed much over the years. We will do our best to help you understand and utilize your benefits. The amount of coverage your insurance provides is strictly a function of the policy selected by **you and your employer**.

We will be happy to file your insurance claims for you and to help maximize your benefits. The amount that insurance actually pays varies greatly depending your individual policies and even claim to claim.

NOTE: YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE CARRIER. WE ARE NOT A PARTY TO THAT CONTRACT. AS SUCH, WE FILE CLAIMS AS A COURTESY THAT WE EXTEND TO OUR PATIENTS, BUT ULTIMATLY ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.

Thank you for reviewing our financial policy. We make every effort to explain your costs to you and to avoid misunderstandings so that we can focus on your dental health. If you have any questions, please ask. We are here to serve you.

I have read, understand and accept the terms stated above. I have been given the opportunity to receive a copy of this document.

Signature _____ Date _____