Our Financial Policy

Please understand that payment of your bill is considered part of your treatment.

The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE

WE ACCEPT CASH, VISA, MASTERCARD, AND DISCOVER

WE ALSO OFFER PAYMENT PLANS THROUGH THE LENDING CLUB, CARE CREDIT & CHERRY

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Patient's Initials

Regarding Insurance

We accept multiple insurance benefit plans and we will file all claims as a courtesy for your primary dental insurance and your secondary dental insurance. If your insurance plan does not pay for the estimated amount, you the patient will be responsible for the difference. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance plan. It will be your responsibility to know your insurance coverage policy. We will do our best to help you obtain any information needed. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract.

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Patient's Initials

Fee Estimates

Any fees quoted are guaranteed for 60 days. Insurance quotes are an estimation (our best guess) of what your insurance might pay, we can not guarantee benefits because of limitations in your insurance coverage such as but not limited to (missing tooth clause, pre-existing conditions, waiting periods, cosmetic limitations, downgrading to lesser services, alternate benefits provisions or coordination of benefits)

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Patient's Initials

Scheduling Dental Treatment

To schedule any dental treatment a deposit, of at least 10% of the total cost, will need to be paid in order to reserve the time on our schedule. and for any service other than preventative that exceeds $500.

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Patient's Initials

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary.

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Patient's Initials

Adult and Minor Patients

Adult patients are responsible for full payment at the time of service. The parent or guardian accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been paid prior to treatment. Note: For divorced families, we will NOT split the bill between both parties. We will send the bill to the head of house, which will be the parent who holds majority custody. All billing issues with a split family will be handled outside of our office.

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Patient's Initials

Late Notice Cancellation and No Shows

We require at least **3 business days** notice for canceling a scheduled appointment. For appointments not canceled **3business days** in advance, there will be a minimum $53 inconvenience fee applied to the patients account for preventative appointments, and 10% fee of the total cost for restorative. Please understand for us to continue giving our patients excellent service we need adequate time to fill the broken appointment slots.

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Patient's Initials

Returned Checks

There will be a $35 charge added to your account for any returned check. The total check amount and the service fee must be paid in cash or money order.

Consent of Services

In consideration for the professional services rendered to me , or at my request, by the Doctor, I agree to pay therefore the value of said services to the Doctor at the time services are rendered. I understand that all charges are ultimately my responsibility even if i have insurance coverage, and after 90 if my insurance does not pay I will be billed for the entire balance. I understand that should I breach this policy a suit could be brought against me I agree to pay all costs and attorney fees if a suit is filed. In the event that my account should be turned over to an outside collection agency, I agree to pay all costs incurred by said collection agency.

_____ _____

Signature of Patient or Responsible Party Date

HIPAA Regulation FORM

Patient Consent

Patient Name: _____DOB:_____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Telephone Number:_____ Sex: M ◯ F ◯

Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

I, _____, hereby authorize the release of my patient information, i.e., appointment dates and times, account balance, and/or needed treatment, to the person/s below:

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

Patient Signature: _____

Date: _____

Witness Signature: _____