

Office Policies

Payment for services is ultimately the responsibility of the patient/guarantor. Your dental plan is designed to share in your dental care costs. It may not cover the total cost of your bill.

Patients with Insurance:

Patients with insurance are required to pay their copay and deductible at the time services are rendered. We will make our best effort to properly calculate your copay. If we overestimate your copay, the excess will either be credited to your account or refunded to you by check. If we underestimate your copay, the amount will be billed to you. As a courtesy we will process your insurance claim.

NOTE: If a particular service is not covered fully, you will be responsible for the remainder of the fee. If a particular service is not covered at all, you will be responsible for the full fee. For portions not covered by insurance, you may choose from the options below.

Children under 14 must be accompanied to their appointments by a parent/guardian. Minors 14 and over who come to appointments on their own must be prepared to pay the appropriate amount. If a patient does not have payment, we will not be able to treat them that day.

Portions Not Covered by Insurance:

Payment in full is expected at the time service is rendered. The following options are available for larger procedures exceeding \$300:

1. CARE CREDIT: Interest free plans are available to those who qualify. Several low-interest plans are also available for extensive treatment plans. Approval is by phone with no paperwork to fill out.
2. Cash, check, and major credit cards accepted (MC, VISA, DISCOVER, AMERICAN EXPRESS).

Cancellation Policy:

The appointment made is reserved especially for you. We require a ***minimum of 24 hours notice*** for cancelled appointments. There will be a \$50 charge for missed appointments. If you miss an appointment that is an hour-and-half or longer, you will be asked to make a deposit of one-third of the total cost of the visit for future appointments of that length. Patients who repeatedly cancel appointments without notice will be asked to seek care elsewhere.

Policy on Returned Checks:

A fee of \$30 will be assessed for any checks returned from the bank due to insufficient funds.

I have read the above financial and cancellation policies and agree to abide by them. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.**

SIGNATURE _____ DATE _____

A COPY OF THIS AGREEMENT WILL BE PROVIDED UPON REQUEST.