



Our Financial Guidelines

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful, and as such, payment is considered part of your treatment.

Patient's portion is due at time of service

- We accept cash, check, Visa, MasterCard, Discover
- We offer Care Credit Financing, if approved

As a courtesy to our patients, we will file your insurance claims for you. It is our policy to collect the estimated patient portion at your appointment. Please keep in mind that your insurance is a contract between you and your insurance company and does **NOT** guarantee payment. We will prepare and mail your insurance claims, but ultimately the responsibility is the insured. We cannot bill your insurance company unless you provide us with your insurance information and a proper identification number for the insurance. We also require correct insurance ID numbers, social security numbers and correct birth dates. If the insurance company does not pay the claim within 60 days the account will be due and payable within 10 days of billing. It will then be the insured's responsibility to pursue reimbursement from the insurance company. If need be we will provide the necessary documents to the patient.

Regarding Insurance: 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 rate. Our treatment estimates are **ONLY** estimates. We can never guarantee what your insurance will cover.

Our Appointment Guidelines

We offer convenient office hours to serve our clients and we reserve appointment times exclusively for each patient. We will work with you to schedule appointments that maximize your care in the shortest number of appointments.

- When we reserve an appointment for a patient, that patient is the only one scheduled at that time. The focus of the doctor and/or hygienist is only on that patient's care and the time allowed is very important. Each appointment in a patient's treatment schedule moves them closer to completing their needed dentistry. Please allow 48 hours cancellation notice. Anything less is subject to a \$30.00 late cancellation fee.

If you should find it necessary to change your appointment, please do so within two business days to avoid a missed appointment fee.

I have read the above guidelines. I understand and agree to these guidelines.

Name _____ Date _____

Signature _____