FINANCIAL POLICY

In order to assist you in making payments for your treatment, we have provided the following options. Please read them carefully and feel free to discuss any questions or concerns you may have with us.

IF YOU DO NOT HAVE INSURANCE:
Payment is due in full at the time treatment is provided.

PAYMENT:
You may make any payment using cash, check, MasterCard or Visa.

IF YOU HAVE INSURANCE:
We will submit your claim to your insurance carrier for you. You are responsible, at the time of your appointment, for any deductible or co-payment NOT covered by the insurance company. If the exact amount covered by the insurance company cannot be determined at the time of your appointment, we will calculate an estimate based on the national average of insurance payments (100% for prevention, 80% for restorative, and 50% for major work). Once our office has received payment from your insurance company you will be billed for any amount still owed or you will be issued a refund check for any credit remaining.

INSURANCE PATIENTS – PLEASE READ CAREFULLY:
The amount of coverage paid by your insurance carrier may be based on your company's own reduced fee schedule for treatment and may be less than actual charges resulting in lower coverage to you. *We have no control over this agreement that was made by your company and the carrier.* Lower payment is a direct result of the plan selected by your employer. Please be advised that WE CANNOT WAIVE CO-PAYMENT. We are required BY LAW TO COLLECT CO-PAYMENT.

MULTI-VISIT PROCEDURES:
Multi-visit procedures include crowns, bridges, and root canal treatment. Special arrangements may be made for these multi-visit procedures. Please see our Care Coordinator for payment plans.

CANCELLED OR BROKEN APPOINTMENTS:
No charge will be made for canceling and rescheduling an appointment provided *48 hours notice* is given. Otherwise, there will be a $50 charge for a broken appointment. Once an appointment has been made, please remember that this time has been reserved specifically for you.

COLLECTION FEES:
You will be liable for any collection fees incurred in the process of obtaining your payment.

FINANCIAL CONSENT:
I certify that I have read, understood, and agreed to this financial policy, and that it applies to me and any of my dependents.

Person Responsible for Account:_____ **SS Number:**_____
Address:_____ **Date of Birth:**_____

SIGNATURE: X_____