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FINANCIAL POLICY

You will be billed for your dental care. The balance is due in full within 30 days of the billing date on your statement. If you wish to pay at the completion of your visit, we accept cash, check, or the following credit/ debit cards: Visa, Mastercard, American Express and Discover.

If you have dental insurance, we will gladly submit your claim to your dental insurance company for you. Payment from the dental insurance company is expected within sixty (60) days of billing. **Please remember you are fully responsible for all fees charged by this office regardless of your insurance coverage.** Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract and there is nothing we can do regarding the coverage provided. As dental health care providers our relationship is with you, not your insurance company. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. A few insurance companies reimburse on an arbitrary "schedule" which bears no relationship to the current standard of care or the actual cost of providing dental services; not all services are a covered benefit in all contracts and some companies arbitrarily select services which they can exclude. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

It is important for patients to review and understand their dental insurance plans. Many plans have waiting periods, frequency limitations, a calendar year maximum, exclusion clauses, copayments and deductibles. It is important if you are establishing as a new patient that you check with your insurance carrier on services that have a frequency limitation. On most dental plans, radiographs, examinations and adult prophys (cleanings) generally have a frequency limitation. If for some reason, you provide improper/wrong information (such as wrong insurance company or contact information) then you will be responsible for the entire billed amount. All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage.

On some occasions, the dental insurance company may send the check for completed treatment directly to you, the patient, instead of to our office. If this occurs, please bring the check into our office with the appropriate Explanation of Benefits so that we can credit your account properly. If you keep the insurance check, then you will be responsible for the entire billed amount.

We would be happy to discuss our charges and how they relate to your particular situation. Some treatment may necessitate special financial arrangements. Please feel free to discuss your concerns with our team at any time. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Returned checks for insufficient funds or closed accounts are subject to a $35.00 fee. If a check is returned, cash, Visa, MasterCard or Discover will be the only accepted form of payment thereafter.

If you fail to pay off your account balance within ninety (90) days of your first statement, we reserve the right to file a claim with a third party collection agency or lawyer. We also reserve the right to charge a billing fee to unpaid/ outstanding accounts. If a collection agency becomes involved in the settlement of your account, all collection costs and legal fees for both parties are the responsibility of the account holder.

By signing below I acknowledge that I have read and understand the above policy.

Signature _____ Date _____