STATEMENT OF FINANCIAL POLICY

Our practice is committed to providing you with the best possible dental care. Your clear understanding of our **Financial Policy** is important to our professional relationship. Our office payment policy is that payment is due at time of professional services rendered. In order to assist you better, we provide you with the following options for your convenience:

1. **Cash, Check, Check-Card**
2. **Credit Cards (Visa, MasterCard and American Express)**
3. **Smile Care Plan**

INSURANCE: **Due to the unpredictability of insurance reimbursement for dental care, we are not able to determine 100% guarantee of insurance benefits.** Our office will retrieve dental benefits and bill your dental insurance company as a courtesy to you. We will collect a co-payment (if applicable) based on your dental treatment and insurance coverage. All your benefits and treatment plan will be explained to you thoroughly by the office manager and/or attending before treatment is rendered. Should the insurance differ in payment that was originally expected, the patient and/or responsible party will be held responsible for the difference in payment. **If your insurance company has not paid the full balance within 30 days, you will have 7 days to pay the balance in full.** If your insurance company should make an overpayment to us, we will notify you.

Insurance is a contract between you and your insurance company. We are not a party to this contract. We cannot become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, **effective and termination dates,** etc. other than to supply factual information as necessary. **You are responsible for the timely payment of your account.** Our office staff will assist you in obtaining insurance reimbursement to the best of our abilities.

Scheduling for Major Services **(Crowns, Bridges, Dentures, Veneers, Implants, Invisalign): At any time we schedule any major services with you, we expect full payment of Co/Pays if insurance applies**. If you do not carry any type of coverage, a deposit will be mandatory for payment once scheduled for treatment. If cancellations are to occur while the deposit is on hold, we will collect a 15% interest charge fee from the deposit made.

CANCELLATION POLICY: Unless notified at least **24 hours in advance**, **our office policy is to charge each patient and for each hour no less than $50.00.** Our time is as valuable as yours, so please be courteous enough to let us know in advance should you need to change your appointment time and/or date.

I understand that all responsibility for payment for dental services provided in this practice for myself and/or dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 ½ % finance charge (18% APR) may be added to my balance, in addition to any collection charges.

Patient's or Responsible Party's Signature **Date**