



FINANCIAL POLICY

Our fees are based on the cost associated with providing quality and personalized dental care. At times, this may correlate with your dental insurance benefits, or what your insurance company has called "USUAL AND CUSTOMARY FEES". In reality, this term means the dollar amount your insurance allowance is for a given procedure. Insurance should be viewed as an aid to meeting your financial obligation to this office. In some cases your insurance may not cover all the fees. **YOUR INSURANCE IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY, NOT BETWEEN YOUR INSURANCE COMPANY AND THE DENTAL OFFICE.** As a courtesy to our patients, our office will complete any necessary insurance forms and file these with your insurance company at no charge. It is to be understood and agreed that services rendered are charged to you directly and you are personally responsible.

Initials _____

Based on the information you have given us at your initial visit, we will contact your insurance company to get obtain your specific benefits. This information will enable us to give you an estimated amount due for each visit. **REMEMBER, DEDUCTIBLES AND BALANCES NOT PAID BY THE INSURANCE COMPANY ARE YOUR RESPONSIBILITY AT THE TIME OF SERVICE.** If you would like to make financial arrangements, we offer Care Credit financing services, allowing you a period of interest free financing.

SCHEDULED APPOINTMENTS

We reserve the right to charge for appointments canceled or missed without a proper two business day notice. Your appointment is a specific time reserved exclusively for you. If for any reason you are unable to keep a scheduled appointment, we do require a two business day notice of cancellation. Broken appointment fees are \$25 per hour.

Initials _____

We will respect your time, and in return we appreciate our patients being on time for scheduled appointments. If you are running late please phone ahead to let us know. If you are over 15 minutes late for your appointment, we may need to reschedule.

If the total cost of your appointment exceeds \$2000 we may require a deposit to be paid at the time of scheduling to reserve your appointment time. This amount will be determined based on the treatment scheduled and will be discussed at the time of scheduling. The deposit will be applied to your total patient portion due to the office at the time services are rendered. Please keep in mind if you miss your appointment or it is cancelled without 48 hour notice the deposit paid is forfeited and applied towards a cancelation fee. A new deposit will be required to schedule another appointment.

Initials _____

I have read this financial policy and understand it completely.

Signature _____ Date _____

Printed Name _____