

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment guidelines.

Any services rendered under \$225, we ask you to take care of the day of the appointment. The insurance company will mail any insurance benefit you have to you. Any amount over \$225, we will gladly make financial arrangements for your convenience.

PAYMENT for services is due upon completion of treatment unless payment arrangements have been approved in advance by our staff. We accept cash, checks, American Express, MasterCard, Visa, Discover, Care Credit, or Dental Fee Plan, and we will be happy to help you process your insurance claim form for your reimbursement. A completed insurance form for each procedure must accompany any such request.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You **MUST** realize, however, your insurance is a contract between **YOU**, your **EMPLOYER**, and the **INSURANCE COMPANY**. We are not a party to that contract. We must emphasize that as dental care providers, our relationship is with you, not the insurance company. While the filing of insurance claims is a **COURTESY** we extend to our patients, all charges are **YOUR RESPONSIBILITY** from the date the services are rendered. If you experience any financial difficulty, we encourage you to contact our office.

1. In order to contain the cost of dental care for you, guidelines have been established regarding missed appointments. Many patients need our services and missed appointments inconvenience everyone. A charge of \$50.00 will be made unless we receive a minimum 24-hour notice. In the event you miss a rescheduled appointment that was rescheduled due to an initial missed appointment, a charge will be made for the full amount of the scheduled appointment.
2. Fees will be quoted prior to the initiation of treatment. If you have insurance coverage, we will expect you to be responsible for your portion. If you do not have insurance, 100% is to be paid upon completion of treatment, unless prior arrangements have been made.
3. All checks returned for any reason will be assessed a \$45 service charge.
4. We encourage anyone having temporary financial problems to contact us immediately so we can assist you in the management of your account. Any account over 95 days delinquent will be placed into collections. In the unpleasant event this occurs, the patient/legal designate/responsible party will assume **ANY AND ALL** collection and/or legal costs incurred, in addition to the outstanding balance.

I acknowledge I have read and agree to the above stated guidelines by signing below.

Patient/Legal Designate Signature

Date