Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health.

The following is a statement of our Financial Policy, which we require that you read, agree to initial each section and sign prior to any treatment.

_____ **PAYMENT IS DUE AT THE TIME OF SERVICE**

We accept cash, personal checks, Mastercard, Discover, American Express and Visa. When insurance applies, we will collect any deductible and estimated co-payment at this time.

_____ **INSURANCE**

- As a courtesy to you, we will help you process all your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for details of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.
- All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. And authorizes the release of any information concerning your (or your child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid.
- We do not bill medical insurance for services rendered at our clinic.

_____ MONTHLY BILLING

Even though an insurance claim has been filed, you may receive a statement each month if there is a balance due on your account, since you, not the insurance company, are responsible for payment of your account.

_____ COLLECTION FEES

Fees incurred to enforce payment required by this agreement will be charged to the patient whose failure to pay, required these fees to be incurred.

_____ MINORS

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service. Unaccompanied Minors: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency treatment may be denied.

_____ MISSED APPOINTMENTS AND CANCELLATIONS

In order to provide the best services for our patients, we require at least 48-hour notice for cancellations or for rescheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A $50 fee per hour of scheduled time will be charged for missed and short notice (less than 48 hours). Multiple failed appointments may result in being dismissed from the dental practice.

_____ CONSENT

I have read, understand, and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

_____ COMMUNICATION

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. We or our agents may call by telephone regarding your account. You agree that we may place such calls using an automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device. You agree that we may, for training purposes or to evaluate the quality of our service, listen to and record phone conversations you have with us.

Signature_____ Date_____