Cosmetic & Comprehensive Dentistry

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NO SURPRISE FINANCIAL POLICY

When one is in the midst of being treated for a medical or dental problem, it is easy to forget that a health care office is also a business. We understand that. We also want our patients to understand that an important part of any business is collecting payment for services rendered. In the interest of providing excellent health care and doing good business, we believe it is best to establish a financial policy to avoid any misunderstandings. Therefore, we have developed the following financial policy:

YOU ARE RESPONSIBLE FOR PAYING YOUR BILL

Even if you have medical or dental insurance, remember that your coverage is a contract between you and your insurance company. Please note: We are out of network for all insurance companies other than Delta Dental. We are a private, fee for service health care office. We do not have a contractual agreement with any insurance company other than Delta Dental. We are not a preferred provider nor are we part of a DMO. If we were, we would be obligated to them and not to you, the patient receiving the services.

If your insurance company requests additional information (e.g. chart copies, detailed reports) we will be happy to provide such information. If you are in litigation and your attorney requires copies of records, detailed reports, and consultations (in-office and phone), you will be billed for these services.

WE REQUIRE THAT YOU PAY AT THE TIME OF YOUR TREATMENT VISIT

We accept cash, checks, MasterCard, VISA, and Discover.

For minor patients, the parent/guardian accompanying the minor is responsible for full payment.

For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to a credit card or payment by cash or check at time of service has been verified.

MISSED APPOINTMENT POLICY

Unless cancelled at least 24 hours in advance, our policy is to charge $45.00 per missed appointment. Please help us to serve you better by keeping scheduled appointments or please reschedule with 24 hours notice.

I agree to honor the policies outlined above. I agree to make full payment for services rendered on the day of the appointment unless prior arrangements have been made in writing. I agree to pay a $10 monthly billing fee if my account is 30 days past due. I also agree to pay all reasonable attorney's fees and costs of collection incurred if my account is not paid as agreed.

Thank you for understanding our No Surprise Financial Policy. Please let us know if you have any questions or concerns.

Signature of Patient/Guardian________________________________ Date____________