FINANCIAL AND CANCELLATION POLICIES

FINANCIAL POLICY

We will bill your insurance company (unless you are self-pay); however, all pre-determined payments are due the day service is provided. Our office accepts cash, personal checks, Discover, Visa, Mastercard as well as Flexible Spending/HSA and Beniversal cards. For charges of $500 or greater, a 5% courtesy will be extended for full cash or check payment **in ADVANCE** of treatment date.

Your insurance is a contract between you and your insurance company. As a courtesy we will provide you with an estimate of coverage and will submit all insurance claims to your insurance provider for you. All charges you incur are your responsibility regardless of insurance coverage. If payment is not received after 60 days, or if insurance claim is denied by your insurance company, you will be responsible for paying the full amount.

Should the fees for professional services not be paid in accordance with the provisions herein, billing and finance charges can and will be applied to all past due amounts. If the account is in default and turned over to collection, reasonable attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due.

Returned checks will be subject to a $25 bank fee. We retain the right to refuse checks as payment.

CANCELLATION POLICY

As a courtesy to other patients our office must be given **at least a 24 business-hour notice** if you need to cancel or reschedule a dental hygiene (cleaning) appointment. Procedural appointments (for fillings, crowns, extractions, etc) must be cancelled with **at least a 48 business-hour notice**. If a notice is not given, you will be **charged $35** for each scheduled dental hygiene visit and **charged $70** for each scheduled procedural visit. These charges are **non-remittable to insurance and must be paid before the missed appointment can be rescheduled**. We may also request full payment prior to reserving future time in our schedule. Our office holds the right to remove any appointment from our schedule.

AUTHORIZATION AND RELEASE

I certify that I have read, understand and agree to the above information to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and records of any treatment or examine rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If your account becomes delinquent and is sent to collection you will be responsible for all service, collections and attorney fees. A **GUARANTOR** is the person held accountable for the patient's bill. In our office, **a guarantor for a child is the parent that presents the child for care at each visit.**

_____ _____

PATIENT(S) NAME(S) **TODAY'S DATE**

_____ _____

GUARANTOR – PRINT **GUARANTOR - SIGN**