Our Financial Policy

Thank you for choosing us as your dental health care provider. We are dedicated to helping elevate our patient's oral health to the highest level possible in a caring, professional and timely manner. We, in return, ask that our patients pay for these services in the same expedient manner as we render them. Payment of your bill is considered part of your treatment. Insurance coverage varies with the many insurance companies available. Our policy is to estimate insurance coverage at 80% for most dental services, with 50% for major services, including bridges and dentures. The 20% (or 50%) we estimate as your portion is due from you at the time of service.

We accept cash, checks, Visa, Master Card, and Discover.

We accept assignment of insurance benefits as a service to our patients, but the responsibility of payment of your account rests solely with you in the event your insurance company does not pay, for whatever reason. We will file insurance claims for you, but we cannot do that unless we have all the correct information, including a copy of your insurance card, if applicable. We are not a party to your insurance contract.

For minor children: Payment of the account is the responsibility of the parent signing this agreement.

Our practice is committed to providing the best treatment for our patients and our fees are within the range for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of covered expenses.

If an account remains unpaid for a period of 90 days, we have the right to assess a finance charge to the remaining balance of the account, until the account is paid in full. The amount of the finance charge is to be determined at the rate of 1 ½% per month.

In the event of default, the undersigned will pay reasonable collection costs including, but not limited to, attorney fees and court costs.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read this financial policy. I understand and agree to this policy.

_____date_____

Signature of patient, or responsible party

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