# FINANCIAL POLICY

**Patient name: _____**

We welcome you to our practice and we are committed to your treatment being successful. Please understand that payment of your bill is part of your treatment. The following is a statement of our financial policy which **we require you to read and sign prior to any treatment**.

Payment is expected as services are rendered. If you are covered by insurance, we expect payment for deductibles and co-payments on the date of service. We accept payment in form of cash, credit card or check. Third party financing such as Care Credit may also be available for you. Please ask if you need it.

**Patients with Insurance**

Your insurance benefits are determined by your employer, not your dentist. It is your responsibility to provide the information which allows us to verify the insurance coverage. If this information is not provided to us in a timely manner, we will be unable to bill your insurance company and you will be expected to pay in full for the services rendered. If we have not received the payment from your insurance company, within 45 days of billing, the balance becomes your responsibility. We will always be willing to assist you with any additional information you may need.

We will do everything we can to ensure that you receive the full benefits of your policy. Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. You will be expected to contact your insurance company directly in case of a problem.

(Initials_____)

**Usual and Customary Rates**

Our practice is committed to providing very high quality of treatment and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please note that we can only estimate what your insurance (if any) will pay since each insurance company has its own limitations and exclusions.

(Initials_____)

**Billing Policy**

We assign all accounts over 120 days to a collection service for processing. Should this account be past due, you agree to pay any reasonable additional fees, including any and all collection agency, legal fees and/or court costs necessary to collect this amount.

(Initials_____)

**Cancellation and Broken appointment policy**

**Two business days notice is required for rescheduling appointments**.

I agree to this financial policy and I have read and upon request received a copy of this policy statement.

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Patient or Parent/Guardian Signature

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Date