Office Policy

Payment for services is expected at the time service is provided. We accept cash, personal checks, Visa, Discover Card and MasterCard. If an extended payment plan is desired, please ask us about our financing programs.

I understand and agree that if I miss any scheduled appointment without providing at least 48 hours notice, except in extenuating circumstances as determined by this dental office, I can be charged a "no show" fee of $25.00 per half hour that I was scheduled. This would be no different than if I had failed to show up to a hotel or airplane flight. I understand that this charge will not be able to compensate the doctor and his staff fully for their time and I agree that this charge is fair and reasonable. **In addition, if I am more than 15 minutes late to an appointment, this dental office may reschedule my appointment and charge me a fee of $25.00 per half hour that I was scheduled.** This fee must be settled prior to scheduling any future appointments. I understand that my tardiness may result in the excessive waiting of other patients, and that both rescheduling my appointment and the late fee are reasonable and appropriate.

I understand and agree that all services rendered me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment in full off the account. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, 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. Finance charges will be applied to all accounts after 60 days at the rate of 1.5% per month (18% annual rate). If the account is in default and turned over for collection, a 50% collection fee and other costs associated with effecting collections will be added. If for any reason you decide to leave our practice, we understand you have the right to request copies of your dental records/x-rays. There will be a $25.00 per person fee to duplicate the records/x-rays. We are required by law to retain the originals on file.

If you have dental Insurance:
As a courtesy, we will file your dental claim for you. We accept direct payment from most insurance companies. Our office does not do any medical billing thus making patients/guarantor's responsible for any medical billing that may be needed. We will estimate your deductible and the portion not covered by your dental insurance, **which is due at the time of treatment**. Our estimates may be different than your dental insurance company's calculations; therefore, the amount due to our office may be adjusted accordingly. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of insurance coverage. **Any insurance claims denied or remaining unpaid after 60 days may automatically become the responsibility of the patient.** Your dental health is of utmost importance to us. Professional care is provided to you, our patient, and not to an insurance company.

The information contained in our treatment plans are not a guarantee of payment from any insurance company. A patient's eligibility and benefits can only be determined at the time the claim is processed. **The patient/ guardian should refer to their benefit booklet for complete dental coverage details. Some insurance companies may pay less for tooth colored fillings (composites), crowns, bridges and other services**. The patient / guardian is responsible for payment on any difference that your insurance may not cover due to the alternate benefit provision, waiting period, and any other limitations. It is the ultimately the patient/guardian's responsibility to be aware of their insurance policy.

The treatment plan presented is only an estimate of services recommended. The treatment plan may be subject to change if the need for a different course of action comes up.

By signing below, I signify that I have read, understand, and agree to each paragraph and provision of this financial agreement. If you refuse to sign this form, all appointments are required to be pre-paid upon scheduling. By having this policy, it allows our office to focus our full attention on your dental needs rather than spending excessive time with financial issues that can limit those needs.

Patient Name: ____ Date of Birth: ____

Guardian Name : ______________________________________
(if applicable)

______________________________ ______________________
(Patient or Guardian Signature) (Date)