

FINANCIAL POLICY

We are pleased to welcome you to our office. New patients are always appreciated. As our patient, please feel free, at anytime, to express any concerns or questions that you may have.

All patient / guarantors are responsible for full payment at the time of service.

If you have any other insurance plan than those with whom we are contracted, fee schedules could be different. That means that your *out of pocket* responsibility could be greater.

Insurance is ONLY an aid for financial assistance to defray a portion of the cost incurred. Your responsible portion will be *estimated* and due at the time of service. We will do our best to file your claims and be of assistance in the process. However, the policy is yours and therefore it is *your responsibility* to be aware of any changes or updates, which must be given to the receptionist prior to your dental visit.

To those with insurance and pending payment, we will allow 45 days for the process to be completed. If, after that time the claim is not paid, the balance remaining will be required to be paid in full. If the insurance company requests information from you, please respond immediately so that the claim can be paid.

Unfortunately, carrying accounts with minimal payments will not be an option. Therefore, a financial program can be made available for your convenience. (*Please check with the receptionist for information.*)

It is important that you give proper notice in advance if you cannot keep your dental appointment. That way, other patients will have opportunity to get in who may be on a waiting list. When you are called as a courtesy to be reminded of your appointment, please return the call for confirmation.

The doctors must remain primarily interested in furthering your good oral health. An understanding for the patient regarding responsibility with insurance and payment of accounts is an important part of having the office run smoothly. We ask that you **please sign this agreement which indicates that you have read, understand and accept financial responsibility for your treatment.**

SIGNATURE: _____ **DATE:** _____