



Our Financial Policy

It is important to us that the quality of our business services matches the quality of our dental care. We want the handling of your account, from the start, to be perceived as an extension of the dental care we provide you and your family.

Patient's Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment at time of services. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone.

Regarding Insurance

At your request, we can attempt to file claims for most dental policies. It is ideal, however, for you to be reimbursed since the contract is between you and your employer. Insurance companies tend to reimburse the insured more quickly than they will reimburse our office. By doing this, our office can keep your health care cost at a minimum while providing exceptional care. We can, with special request, accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. If your insurance company has not paid on your claim within 30 days, you are responsible for the balance in full.

WE ACCEPT CASH, CHECKS OR MASTERCARD, VISA, AMERICAN EXPRESS and DISCOVER.

Ask us about EASY PAY OPTIONS including EXTENDED PAYMENT PLANS and special discounts.

I understand that any unpaid balance after **30** days is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. **I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency.**

I have read the Financial Philosophy. I understand, accept, and agree to this Financial Philosophy.

Signature of Patient or Responsible Party

Date