<u>Financial Policy</u>

Thank you for choosing us as your dental provider. <u>We are committed to providing you with the best possible care.</u> If you have dental insurance, we are here to help you to receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

Initial Visit. Payment in full is required at the time of your initial appointment. We will be happy to help you file your insurance so that you may be properly reimbursed.

Payment Options. Our financial policy was designed to give you a number of payment options to choose from in order to make your payment as easy on you as we can. We accept cash, check, credit cards (Visa, MasterCard, or Discover) or pre-approved extended payment plans. **<u>Payment is due at the time services are rendered unless prior financial arrangements have been made.</u>**

Insurance payment. At the time of service, you will be required to pay the difference between the total amount due less the amount that is <u>estimated</u> that your insurance will cover. We will gladly file your insurance as a courtesy to you. If an insurance claim has not been paid within 45 days, we require that you pay the balance using one of our approved payment options. We ask that you leave a credit card number on file so we may charge your account after insurance reimbursement has been made.

Cancellations/Missed Appointments. We require 48 hours advance notification if you are unable to keep your appointment. Failure to do so **<u>may</u>** result in a cancellation fee of $150.00 P/HR.

Minor & divorced couples: The parent who accompanies a minor for treatment is responsible for any payments or outstanding balances at the time of appointment for services, regardless of primary insurance policy holder.

Service Charges. For those patients with an unpaid balance over 60 days, we may add a 1.5% per month service charge onto the balance. Accounts past due 90 days, the patient will be responsible for all collection cost, court cost, and attorney fees related to collecting the unpaid balance. Please understand that you are responsible for the balance due on your account as a result of any and all professional services rendered by this office. Regardless of your insurance status.

Miscellaneous fees. There will be a $25 fee for a check that is returned for any reason. Fees are charged for services such as copy of medical records, narrative report by the Doctor.

No work will be completed unless balance is paid in full at time of delivery.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account.

I AGREE THAT A CREDIT EVALUATION MAY BE OBTAINED TO DETERMINE FINANCIAL ARRANGEMENTS FOR THIS ACCOUNT.

Thank you for trusting us with your dental care. If you have any questions regarding our financial policy or payment options, please contact our Financial Manager.

I HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISIONS OF THIS FINANCIAL POLICY.

Signature of Patient or Person Financially Responsible for payment on account   Date

5-01-2010