OFFICE FINANCIAL POLICY

This office is committed to providing you with the best possible professional service! In order to help us achieve our goals of delivering outstanding care in a state - of - the - art - facility using the latest infection control measures and instrumentation, it is essential that you assist us in controlling healthcare expenses by understanding our financial policy. **Regardless of whether or not you have insurance, the patient is always financially responsible for his or her account.**

Any fee estimates listed for a particular procedure can only be extended for a period of six months from the date of examination. The patient is responsible for all patient portions or deductibles at the time services are rendered unless other arrangements are made prior to the procedure being performed. Out of pocket expenses may be paid by cash, check or credit card; 0% financing is available for balances over $500 upon request. If an out-of-pocket expense totals more than $550, a 5% discount will be given upon request for payment in full. **We reserve the right to charge $50.00 for any appointments canceled or broken without 24 hours advance notice.**

FOR PATIENTS WITH DENTAL INSURANCE: **As a courtesy to you, we will submit, without additional charge, your claim to your insurance company, usually within 24 hours of the service being provided.** As often as possible your claim is filed electronically! The insurance company is sent a follow-up notice at 30 days, but we shall not wait longer than 60 days from the date of service for payment from your insurance company. **At the end of this 60 day period, if payment has not been received from your insurance company, you are expected to pay the total unpaid portion of your account immediately.** Additionally, upon payment from your insurance company, any unpaid portion on your account is due immediately in full (you will receive a statement from this office). Please remember, you have the contract with your insurance carrier, not us. You are responsible for knowing your benefits, deductibles and exclusions of your policy. While we make every attempt to be informed on these matters, ultimately it is not our responsibility. <u>We do not render services on the assumption that charges will be paid by any insurance company.</u>

A service charge of 1 1/2% per month (18% annually) will be charged on the unpaid balance on all accounts not paid within 60 days of the treatment date unless other arrangements are made. There is a $10.00 returned check fee. If your account has not been settled within 120 days, you will be referred to a collection agency.

If you have any questions about this financial policy, please see the office manager.

Responsible Party's Signature ______________________________ Date ____________

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