Financial Policy

Thank you for trusting us to be your dental health provider. We appreciate the opportunity to serve you. We are concerned about the ever-rising cost of dental care and are dedicated to holding down costs to our patients. Our staff is committed to your successful treatment and well-being.

Please read the following financial policy and information carefully and sign at the bottom of the page prior to treatment. If you have any questions, please ask the front desk receptionist for clarification.

1. You are responsible for payment of the services you receive in our office. Please understand that your dental insurance is a contract between you and your insurance company. You are ultimately responsible for any unpaid balance.

2. There are hundreds of insurance carriers and plans in place today. They can and do change, often yearly, and in some instances more frequently. It is your responsibility to know who your dental carrier is and what your plan benefits are, including co-pay amounts, deductibles, maximums, and covered and non-covered services. We are here to practice dentistry in the best interest of the health of our patients. Often times there is a conflict between what our doctors need to do to practice good dental care and what may be covered by your insurance carrier. You will be billed for non-covered benefit services.

3. Your co-payment is due at the time of service. We accept payment in cash, check, MasterCard, or Visa. We will provide a receipt for all payments. Please retain a receipt for your records.

4. Our billing statements are sent out monthly. Even though you may have an insurance claim pending, you may still receive a monthly statement for your outstanding account balance.

5. We will make every effort to contact your insurance company to get claims paid by mailing in the necessary information and documentation they request. However, if we have not received payment from your insurance company, and/or they are not responding to our claims after 90 days, you are responsible for the balance on your account. After these 90 days it is your responsibility to contact your insurance carrier for further dispute.

I have read and understand the above financial conditions. I agree to the requirements as stated.

Patient/Patient Guardian: _____

Date: _____