FULL PAYMENT IS DUE AT TIME OF SERVICE

Our office gladly accepts Visa, MasterCard, Discover, cash, personal checks, and CareCredit. If you would like to apply for CareCredit financing, please consult our front office staff.

For Patients With Insurance

As a courtesy to our patients with insurance, we will file your dental claims for services rendered. Any amount not paid by insurance is your responsibility. We will be happy to file a pre-determination to the insurance company so we can get a more accurate estimate of what they should pay, but it is still not a guarantee of their payment. You are responsible for paying any deductible and copayment at the time of service. Once we receive payment from the insurance company, you will be required to pay any balance due upon receipt of your statement. The balance due for services provided is the patient's responsibility, even if the insurance company pays nothing. If you have overpaid your portion, you may request a refund or use the credit for additional work that may be needed. If in 30 days your balance remains unpaid, we reserve the right to add 18% annual interest to the unpaid balance.

Delinquent Accounts

We reserve and will exercise the right to report any account 90 days past due to a Collection Agency. All expenses incurred as a result will be the patient's responsibility, as permitted by law.

Cancellations & Missed Appointments

Appointments are valuable blocks of time and when an appointment is broken or cancelled with short notice, we are often prevented from filling that time and helping other patients. Please give at least ***24 business hours notice*** when you will not be able to make your scheduled appointment. This will allow us time to help other patients and helps keep costs down. We reserve the right to charge for all broken or cancelled appointments with less than the required 24 business hour notification. Additionally, if you are more than 15 minutes late for an appointment, you may be asked to reschedule.

All Patients Please Sign

By signing below, I certify that I have read, understand, and agree to this policy.

Patient Signature _____ Today's Date_____