Thank you for choosing us as your dental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE.**

We accept cash, checks, and most major credit cards. We offer an extended payment plan through Care Credit or Prosper Healthcare with prior credit approval.

**ADULT PATIENTS:**

Adult patients are responsible for full payment at time of service.

**MINOR PATIENTS**:

The adult accompanying a minor and the parents (or guardian) is responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, cash or check.

**INSURANCE**:

Most plans are accepted. For those plans, our office will send in the billing claim, however, if there should be little to no cooperation from your insurance we will give the subscriber the responsibility for reimbursement. ***Appeals will be sent to the insurance only once.***

**MISSED APPOINTMENTS**:

Please give us at least **48 hours business day notice** to avoid a late cancellation fee of **$50.00** per hour scheduled. This fee may be more if you are late canceling a lengthy dental appointment. Please help us serve you better by keeping your scheduled appointments.

**LONG APPOINTMENTS:**

A **non-refundable** deposit of $100 per hour scheduled is required. If appointment is cancelled with less than 48 hours notice, or patient is a no show, deposit will not be refunded.

☐ **I CONSENT TO THE DENTAL PRACTICE USING MY CELL PHONE NUMBER REGARDING APPOINTMENTS, TREATMENT, INSURANCE AND MY ACCOUNT. I UNDERSTAND THAT I CAN WITHDRAW MY CONSENT AT ANY TIME. MY CELL PHONE NUMBER IS _____.**

Thank you for taking the time to read our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy above. I understand and agree to this Financial Policy.

| _____ | _____ | _____ |
|---|---|---|
| Signature-<br>Patient or responsible party | Printed Name | Date |
| _____ | _____ | _____ |
| Staff Member | Printed Name | Date |