OUR FINANCIAL POLICY

I understand that I am responsible for ALL fees regardless of insurance coverage. My patient responsibility is **due at the time services are rendered** and this financial responsibility may be based on estimated amounts/percentages from my insurance company should active insurance be presented.

I also understand that as treatment progresses, modifications may need to be made and could be adjusted. I will be informed of any adjustments or treatment changes and how these changes will affect my payment as they occur.

I understand that your office works hard to coordinate schedules based on the needs of your patients and that you provide sufficient time for treatment to be completed. If appointment changes or cancellations are made without providing at least a 24-hour notice, I understand that I may be charged a missed appointment fee of $50 per hour missed.

We accept cash, check, and most major credit cards as form of payment.

I confirm that I have fully read and understand the above and agree to comply.

Signature:_____ Date:_____