Financial Policy

In our continued commitment to provide the highest quality of dental care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment.

Please check the following that apply:

* Cash, personal check
* Visa, MasterCard, Discover, American Express
* Automatic credit card payment (balance to paid in 4-6 months)
* Care Credit (pending approval)

We are committed to support you in understanding your dental health, so that you will always be able to make the best choices. We will always present you with the best dental solution possible to treat your personal situation.

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed at this office: this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that all services are due to be paid in full within ninety (90) days of date of service, regardless of whether or not my insurance benefits have been received. A $5.00 per month billing charge will be applied to my account beginning 90 days from treatment on any balance due. I also understand that should credit be extended to me by this dental office, a credit check will be made through a credit service and I authorize release of all financial data. I agree to pay a fee of $40 if an appointment is missed or cancelled after 48 hours prior to my appointment. I understand if major dental procedures are rendered such as dentures, partial dentures, crown and bridge or implant restorations a 50% deposit will be required at the time the procedures begin. The remaining balance is due at the time the treatment is cemented or inserted.

We are here to assist you in any way possible. Please make your questions and concerns known to our team…Our goal is to ensure that you have an outstanding experience.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (responsible party) / Print Name Date