APPLESEED DENTAL

Written Financial Policy

Thank you for choosing Appleseed Dental. Our primary mission is to deliver the best and most comprehensive dental care available. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health.

Payment:

We offer several payment options for your convenience:

- We accept Cash, Check, Visa, MasterCard, Discover and American Express - We offer convenient monthly payment options from **Care Credit Healthcare Credit Card**. There is a **$25** fee for returned checks.

Insurance:

Our office is committed to helping our patients maximize their benefits. Dental insurance is becoming extremely complex. We are always available to answer your questions. Nevertheless, your insurance policy is an agreement between you and your insurance company. As a dental provider, we are not party to that agreement. As a courtesy, we are happy to submit to and work with your carrier to maximize your benefit. Any insurance information is strictly an estimate, and is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles, and maximums which are your responsibility. We will attempt to verify eligibility before your appointment, but this is not a guarantee of payment from your insurance company. All charges you incur are your responsibility, regardless of insurance coverage.

There will be a minimum of 50% of expected payment required at the time of service for any dental procedure that requires the service of a laboratory (crowns, bridges, dentures, etc.)

Missed Appointments:

We appreciate your choosing our office to provide your dental treatment, and we work diligently to give you the best dental care available in a timely manner. We respectfully request that you make every effort to keep all appointments or call our office at least 48 hours prior to reschedule.

A fee of **$40** may be charged for multiple missed or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

Financial Consent:

The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office. I understand and agree to this Financial Policy and Agreement. Furthermore, I authorize release of any information relating to any claim or any insurance information. I understand that I am responsible for all dental treatment not covered by my insurance.

UNACCOMPANIED MINORS:

The parent or legal guardian is responsible for payment in full at time of service. Treatment consents and payment arrangements must be made prior to the appointment or non-emergency treatment may be denied.

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Signature of patient/responsible party Date

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Print name of patient/responsible party