Consent for Services and Financial Policy

As a condition of this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. We require that at the time our services are performed, our fee will be paid in full. We accept MasterCard, Visa, Discover, cash and personal checks for your convenience. There is an available line of credit through Care Credit should you qualify. (Please see the link to Care Credit on our office location page to submit an application for credit approval).

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients with dental insurance understand that all dental service are charged directly to the patient and that he or she is personally responsible for payment of all dental services. However, our office will attempt to submit the patient's insurance forms as a courtesy to assist in making collections from insurance companies. We will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Patients are required to pay their estimated co-pay due on the day of their appointment for services rendered. For major services such as crowns, bridges, dentures and partials, we expect your estimated portion of the entire procedure paid on the first visit. If there is a remaining balance on the patient's account after 60 days of submitting the insurance claim, we will bill the patient for the remainder due. Full payment is expected upon receipt of that bill. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days.

For those who pay with a personal check, should it be returned to our office for insufficient funds, your account will be charged a non-refundable $25 per occurrence.

I understand that any fee estimate for a dental treatment plan can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing. I further agree that the charges for services shall be as billed and I agree to pay all costs.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.