Chris L. Adkins, DDS
Financial Policy

Thank you for choosing our office to provide your dental health care. We are committed to providing the best, safest and most aesthetically pleasing treatment available. This document is a statement of our financial policy which we require you to read and sign prior to any treatment.

PAYMENT IS DUE AT THE TIME OF SERVICE. PLEASE SELECT YOUR METHOD OF PAYMENT:

- Check or Cash at time of treatment ($25 fee for returned check)
- VISA, Mastercard, or Discover
- Insurance, with co-payment, at time of treatment
- Financing (available through CARECREDIT, a third party financing service for health care treatments requiring credit approval.)

Regarding Insurance

We accept private care insurance plans. All dental plans are different and are based on an agreement between the patient's employer and the insurance company. Our office is not part of that contract. We bill your insurance company as a courtesy and collect your estimated portion at the time services are rendered. Although we are able to estimate your portion, we cannot guarantee any out-of-pocket expense. After a period of 60 days of non-payment by an insurer, the entire bill becomes the responsibility of the patient.

Usual and Customary Rate

Our practice is committed to providing the very best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary.

Minor Patients

Minor patients should be accompanied by a parent or responsible adult. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan or credit card or payment by cash or check at the time of service has been verified.

Missed Appointments

We carefully schedule our appointments so that each patient has our full focus and attention during their allotted appointment time. If you are unable to keep a scheduled appointment, we ask that you notify our office as soon as possible. Appointments that are not cancelled at least 24 hours in advance are subject to a charge of $50. Please help us to best serve all of our patients by keeping scheduled appointments.

I have read, understand, and agree to the Financial Policy of Chris L. Adkins, DDS.

X___________________________________ Date__________________________

Signature of Patient or Responsible Party

Please print patient's name ____