Office Financial Policy

We are pleased to offer the following payment options for your convenience:

☐ **Personal Credit Cards**	☐ **Cash or Personal Check**
☐ VISA ☐ MasterCard	We offer a 5% discount at time of visit when a patient's estimated balance is paid in full.

Two additional financial options which are administered for us by:

☐ **Carecredit** ☐ **American General Financing**

(Please ask for additional information regarding these services)

1. **Full payment is expected at the time of service** unless prior arraignments are made (see above for cash discount). Patients will be charged $30.00 for any check returned for non-sufficient funds (NSF).

2. **As a courtesy to our patients**, we will bill the insurance company for services rendered. However, we do not act as an agent of the insurance company. The insurance contract is between you, the patient, and the insurance company; therefore, ***the patient is responsible for the bill regardless of insurance coverage.***

I agree that I am fully responsible for the total payment of all procedures performed in 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 sixty (60) days, regardless of whether or not my insurance benefits have been received. One and one-half percent (1.5%) per month interest (18% annually) will be charged on accounts 90 days from the treatment date. I agree to pay a $5 billing fee for each month my balance remains outstanding and statements are generated. I also understand that should credit be extended to me by this office, a credit check will be made and I authorize release of all financial information. Patient will be charged $30.00 for any check returned for non-sufficient funds (NSF).

We ask for at least a 48-hour notice if you are unable to keep a scheduled appointment. There is a $60.00 charge for missed or broken appointments with less than the required notice.

We are here to assist you in any way possible. Please make your questions and concerns known to our helpful staff.

X _____ _____ _____

Patient Name (Print) *Patient Signature* *Date*