Important

Financial Policy

In an effort to keep dental costs down while maintaining a high level of professional care, we offer these office arrangements and policies for our services. It is important to read ALL policies.

- **Payment in full** due for services rendered or estimated co-payment if filing dental insurance.
- **Cash, check, all major debit/credit cards, and money orders accepted.**
- **Major treatment** such as crown, bridges, partials and dentures will require an appropriate down payment with payment in full upon delivery.
- **Extended payments** are available through our Care Credit plan. This plan allows up to 6 or 12 months of payment arrangements with no interest.
- A **$30.00 service fee** will be applied for all returned checks.
- A **$40.00 service fee** per scheduled hour will be charged to your account for all failed appointments without 24 hour notice of cancellation.
- **All costs associated with collecting the balance of a delinquent account** will be added to and become part of the principle balance due this office. This may include but is not limited to court costs, filing fees, attorney fees and/or collection agency fees. All uncollected balances are reported to a national public credit bureau through Advanced Collection Agency.
- **Insurance is filed one time as a courtesy to you.** You are expected to pay any deductible and co-payment amount on the day of service. All balances are your responsibility whether or not an insurance company has paid on the account. If the insurance company is one that pays you directly, you are required to make financial arrangements to cover the entire balance of your account. We will not be placed in a position to wait for the insurance company to pay you first.
- **We are OUT OF NETWORK for all dental insurance companies except for Active Military and SunLife Financial. We accept all dental insurances but only IN Network with the above mentioned.**

I understand the above financial policy and agree that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other firm financial arrangements have been made.

Patient Signature_____ **Date**_____