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FINANCIAL POLICY

Thank you for selecting our office as your dental provider. The following is a statement of our financial policy which we ask that you **read, understand and sign prior to any treatment.** We are committed to the best possible dental care and we are happy to discuss our professional fees with you at any time during our normal office hours. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy, or your financial responsibility. Payment is requested at each appointment as service is rendered and can be made by **Cash, Check, Master Card, Visa, American Express, Discover, or Care Credit.** Please be aware that if you are a parent bringing a child to our office you are legally responsible for payments on all charges. We cannot send statements to other addresses. **Delinquent accounts may incur finance charges and/or administration fees. You are responsible for any fees incurred**.

DENTAL INSURANCE INFORMATION

As a courtesy to you, our patients, we will file your dental insurance claim for you. We also, as a courtesy to you, will accept assignment of benefits. We will only accept this assignment of benefits after you are a patient of record with us. Once we have verified your insurance benefits, we will begin filing your claims for you. For appointments such as cleanings, we will bill the insurance company, if you need to return for restorative treatment, we will collect your yearly deductible at the time the service is rendered. If you are in need of a crown, bridge, or denture, we ask that you pay a portion of what you will be responsible for at the initial appointment, and that the remaining portion be paid at the delivery appointment. Please keep in mind we estimate what we think the insurance will pay. Once the insurance company reimburses us, you will be billed for any remaining balance,

You, the patient, are responsible for your entire account balance. If, for some reason, your insurance company becomes unduly difficult to deal with, we ask that you proceed with whatever measures you deem appropriate to collect on your claim. Please provide us with the following Information in order to file your claim:
Patient's Name: ____
Subscriber's Name: ____ DOB: __________________
Subscriber's Social Security Number: ____
Company Where Employed: ____
Insurance Company Name & Number: ____

**I authorize the release of any information concerning mine or my child's dental care, advice, and treatment provided for the purposes of evaluating and administering claims for insurance benefits.
**I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me and I understand that I am financially responsible for payments in full of all accounts.

Signature of patient, parent/guardian_______________________________ Date:_______________