



STATEMENT OF FINANCIAL POLICY

In the interest of good health care practice, it is desirable to establish a policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good dental health and we wish to spend our time and energy toward that end. Therefore, we wish to clarify the following points:

- **PAYMENT OPTIONS:** All accounts are due and payable at the time of service. If you have dental insurance, you will be asked to pay your estimated coinsurance payment upon check out.
 1. **NO INSURANCE** – pay with cash or check to receive 5% discount; 65 & over will receive 10% discount
 2. **CREDIT CARDS** - Visa, American Express, MasterCard, Discover
 3. **CASH** – **exact change only!** Over payments can be applied as credit to be used for future appts.
 4. **CARE CREDIT** - We offer monthly payment plans through our partnership with Care Credit (No Interest Plans available) We are happy to help get you approved. Ask the front desk for more details.
- **INSURANCE:** We are in network with Delta Dental (Premier), Aetna, Cigna, United Healthcare, Careington, Principle, Ameritas, Guardian, Assurant and Sunlife.

PREMERA BC/BS PATINETS ONLY – Effective 1/1/2023 we will gladly bill your insurance however you will be expected to **pay in full @ time of service** as your insurance will re-imburse you directly.

- **STATEMENTS:** Even though you may have an insurance claim pending, you will still receive a statement each month for the outstanding balance of your account. We cannot accept responsibility for collecting an insurance claim or for negotiating a disputed claim. Insurance reimbursement is a contract between you and your carrier. You are ultimately responsible for payment of your account.

GUARENTEE OF WORK: We will guarantee our work for up to 24 months after services have been completed provided that you have maintained (2) regularly scheduled preventive appointments annually.

- **NO SHOWS or LATE CANCELS:** In an effort to hold down costs, we ask that you assist us by notifying us within 24 hours if you need to change or are unable to keep your dental appointment. Should you miss appointments without sufficient notice, a charge of \$75 may be applied. (3) or more may result in patient termination.

It is not our intention to cause you undue hardship; however, we must collect our receivables as efficiently as possible in order to continue our service to the community.

I HAVE READ AND UNDERSTAND THAT, REGARDLESS OF ANY INSURANCE COVERAGE I MAY HAVE, I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT. I AGREE THAT IN THE EVENT COSTS AND/OR FEES ARE INCURRED IN CONNECTION WITH THE COLLECTION OF MY ACCOUNT, I WILL PAY ALL SUCH COSTS AND FEES.

SIGNATURE _____

DATE _____