OFFICE POLICIES AND FINANCIAL CONSIDERATIONS

1. Patient is responsible for fees incurred for dental services rendered.
2. Payment is expected when services are rendered. All emergency dental services or services performed without prior financial arrangements, must be paid for at time service is performed.
3. Payment can be made by cash, check, or credit card. (American Express, VISA, MasterCard or Discover). A picture identification card or driver's license is required.
4. Patient can apply for CareCredit which will allow you to obtain financing for your dental care, which may allow you pay to for your treatment with no fees and zero interest if repaid before a predetermined time period. Ask about this at the front desk to find out if you qualify.
5. Short term payment arrangements can also be established with our office front desk coordinators. This in-house financing is only available to patients of record (at least one year), for a period up to a maximum of three months. This can be set up with monthly charges to your credit card.
6. We will process your dental insurance claims for you. (See next page about Dental Insurance). You are responsible for providing us with your correct insurance information.
7. A $7.00 reprocessing fee is charged for any payments not received on a timely 30 day billing period basis.
8. If pre-arranged financial arrangements have been made, payment is expected as scheduled.
9. Checks that are returned from the bank will incur a $45 service charge.
10. You will need to do the best you can, related to weather, traffic conditions and parking, to be on time for all appointments. If you are late, we will do only the services that we still have time to accomplish, or if necessary reschedule the appointment.
11. We must be certain you understand your dental treatment needs, appropriate treatment and options, fees involved and financial arrangements. The estimated fees we provide for dental services are guaranteed for 90 days. If treatment is not begun within 90 days of the estimate date, costs could vary at a later date. Once dental treatment has begun, changes in the anticipated treatment plan may be required, depending on situations that could arise. You will be informed if this occurs of any necessary changes in the treatment regimen.
12. I understand that I am responsible for the fees incurred for my dental treatment, and I agree to pay them accordingly. My signature below certifies that I have read and accept the terms that are listed above.

_____Signature of Patient, Parent, Guardian

or Legal Personal Representative

Date___/__/_____ Relationship to Patient_____