DECLARATION OF OFFICE POLICIES
&
PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing our office as your dental care provider. We are committed to your successful treatment. Our trained team will treat you and your family in the most professional manner and will always be willing to answer any questions you may have regarding your treatment or our office policies. We ask that you take a few minutes to review our policies before we begin our relationship. Please let us know if you have any questions or concerns.

***Statement of Financial Responsibility*:** Our office accepts patients that have dental insurance and patients that do not have dental insurance. Regardless of your insurance status, you are financially responsible for treatment provided to you and/or your legal dependent by this office. Payment associated with any treatment is due at the time of service. Our office accepts cash, personal checks (no third-party checks), cashier's checks, and money orders. There is a $30 charge for returned personal checks. We also accept VISA, MasterCard, and Discover credit cards and debit cards for payment. In addition, we also offer third-party financing for your convenience.

This office, as a courtesy, estimates your insurance coverage and will tell you what you can expect to pay. The estimate is just that, an estimate. The estimate is not a guarantee of payment or coverage by your insurance company. Your insurance policy is a contract solely between you and your insurance company. As a courtesy, we will submit a claim to your insurance company for the treatment. By signing this form, you authorize your insurance plan to make payments for covered services directly to our office. You are responsible to pay at the time of service co-pays, deductibles, non-covered services and services provided by this office. If we do not participate with your insurance or benefit plan, or if your insurance company has not paid the claim within 60 days, your balance immediately becomes due and you must pay the balance and then pursue reimbursement directly from your insurance company. If there is a balance on your account, a statement of charges will be sent to your mailing address and you may receive phone calls from this office and/or a third party asset recovery agency. By signing this form, you authorize this office and its agents to communicate with your dental insurance company, in accordance with their Privacy Policy, regarding policy coverage. You further authorize this office to release information to make payment for services rendered.

Please understand that charges over 60 days past due without a payment plan may be sent to an asset recovery agency and may result in being discharged from the practice. By signing this form, you authorize this office and its agents to release your information in order collect past due balances. By signing this form, you understand and accept that there is a $15.00 late fee for amounts past due greater than 60 days. In addition you understand and accept that all collection fees, attorneys' fees and costs are your responsibility.

***Scheduled Appointments*:** If you cannot attend your scheduled appointment you must call to inform us at least 24 hours prior to your appointment. If you fail to call 24 hours prior to your appointment there is a $50.00 charge. That amount cannot be billed to your insurance company. Please make a simple call.

I have read this form and understand my responsibilities.

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Signature of Patient or Legal Guardian/Guarantor Date

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Printed Name of Patient

Updated: Nov. 2013