

## OUR FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read, and sign prior to any treatment.

Please complete and furnish all insurance information as requested at the front desk.

**PAYMENT IS DUE AT THE TIME OF SERVICE.  
WE ACCEPT CASH, CHECK OR VISA/MASTERCARD/DISCOVER.**

### REGARDING INSURANCE

We require your portion of covered services be paid at the time of service. **The balance is your responsibility whether your insurance company pays or not.** We cannot file with your insurance company unless you give us your insurance information. **Your insurance policy is a contract between you and your insurance company.** We are not a party to the contract. In the event that your insurance coverage changes, please bring your new insurance card at that first visit upon change. **If your insurance company has not paid your account in full within 45 days, the balance will be due by you.**

**Blue Cross and Delta Dental** participants will need to pay in full at the time of service, since the insurance company directly pays you after the claim is submitted. We will still file the claims for you as in the past.

Regarding HPO, HMO and PPO's - we are not a preferred provider with any insurance company. Therefore, we do not accept co-pays.

### TIME OF SERVICE

The parent, adult or guardian accompanying the child is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan - Visa, Mastercard, Discover or payment by cash or check at time of service has been verified.

### INTEREST

We reserve the right to charge interest and any collection fees incurred by us to your account when it is not paid in full. We will no longer have accounts over 60 days old unless they have been pre-authorized prior to treatment.

Please let us know if you have any questions or concerns. I have read, understand and agree to this Financial Policy:

**X** \_\_\_\_\_ **Date** \_\_\_\_\_  
Signature of Responsible Party