FINANCIAL POLICY

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The following statement of our financial policy, which we ask you to read and sign prior to any treatment. Your patient responsibility is due in full at time of service. To accommodate you, we will accept cash, checks, Visa, MasterCard & Discover. For extensive treatment plans we offer extended payment plans and third party financing options.

INSURANCE

We accept most insurance plans. We also accept payment from most PPO and indemnity plans. Patients with Insurance We will do our best to calculate your estimated co-pays for your visit. However please keep in mind that these are estimates only. We cannot know the total cost until the insurance pays the claim, usually 2-4 weeks after treatment.

Therefore some patients can expect a statement with any remaining balance mailed to them with a copy of their EOB (Explanation of Benefits). Co-payments (or estimated patient responsibility) are due before or at the time treatment is completed. The Patient is responsible for any and all fees incurred that are not covered. Patients without Insurance at the time services are rendered, we ask that patients pay the balance in full, we accept Visa, MasterCard, American Express and Discover, as well as cash or check payments.

It is <u>your</u> responsibility to inform us of changes in your insurance coverage. Your insurance policy is a contract between you and your insurance company. We are not a party to the contract.

MISSED APPOINTMENTS

Our policy is to charge for missed appointments at the rate of $50 per missed appointment. Appointments that are failed or canceled with less than 48 hours' notice are then unavailable to patients who need appointments. Please consider your schedule carefully when scheduling appointments.
By initialing here I acknowledge that I am aware of the missed appointment policy X________

OTHER FEES/CHARGES

Returned/Bounced checks will be subject to a $35.00 fee. Balances older than 45 days may be subject to an additional collection fees and interest charges of 1.5% per month.

Thank you for taking time to read and understand our financial policy. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions. Our office manager would be glad to review the financial policy with you at any time.

I have read and understand the Financial Policy.

X_________________________________ _______________

Signature of Patient or Responsible Party Date