Signature Smile
GENERAL & COSMETIC DENTISTRY

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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 part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

General:
Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

Missed or Cancelled Appointments:
Unless we receive notice of cancellation 48 hours in advanced, you will be charged $50.00. Please help us service you better by keeping scheduled appointments. To assist you better we will attempt to contact you 48-24 hours prior to your scheduled appointment by the phone number(s) provided to us. Any appointment rescheduled prior to 48 hours to the scheduled appointment will be recorded. Any appointment cancelled within 48 hours of the scheduled appointment time in your patient recorded as a cancelled appointment. Any appointment not attended and not cancelled will be recorded as a failed appointment. A fee of $50.00 dollars will be charged to your account for not honoring this policy. Every patient will be allowed one recorded failed or late cancellation appointment within a two year period prior to any charges being assessed. We reserve the right to dismiss any patient from our practice on any grounds including cancelled or failed appointments.

Insurance:
Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you our office provides certain services, including pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.
Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

Payment:
FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.
We accept the following forms of payment:

- Cash
- Visa, MasterCard, Discover, Amex
- Care Credit

*If you qualify a monthly payment plan is available for your convenience.

Unpaid Balances over 30 days old will be subject to monthly interest of 1.5% (APR 18%). If payment is delinquent, the patient will be responsible for payment collection, attorney's fees, and court costs associated with the recovery of the monies due on the account

By signing this Financial Agreement, I understand and agree that you are authorized to check my credit and employment history.

I have read, understood and agree to the terms and conditions of this Financial Agreement.

Signature: _____ Date: _____