

FINANCIAL POLICY

Please read carefully and sign to acknowledge understanding and agreement

Thank you for choosing us as your dental care provider. We are committed to providing you with the best dental care available.

Available Payment Options:

You can choose from ~ **Cash, Check, Visa, Mastercard, American Express**

We offer a 5% courtesy adjustment to patients who pay for their treatment, of \$1000 or more, at the time of scheduling your next appointment.

CareCredit payment plan option, ask us for detailed information.

Regarding Insurance:

- **For covered services, we ask that all co-pays and deductibles be paid on the day of treatment.** Since your insurance company may not cover all costs, we ask that you pay any percentage of your balance not paid by your insurance on the day of treatment.
- **For services that are not covered by your insurance, we ask that you pay the entire fee the day of your treatment.**
- We will attempt to answer any questions we can about your insurance and, when possible we will assist in resolving complications with your insurance company. Please understand that we cannot speak on their behalf. Your insurance contract is an agreement between you, your employer and your insurance carrier. In the event that your insurance company has not paid (on your behalf), you will be responsible to pay your account.

Patients Without Insurance:

- **For those patients without insurance coverage, you will be responsible for payment on the day of treatment.** If you are not able to pay in full, or if your treatment requires several visits, you will be given an estimate and will be able to discuss payment arrangements with a member of our business office staff.

Cancellation/No Show Policy:

- Our office requires 48 hours notice to cancel your appointment in the case of an emergency. **We reserve the right to charge a fee, of \$50, for those not giving 48 hours notice.**

Collections

- A charge of \$25 will be added to your account for any returned checks. You are responsible to pay all costs of collecting, or attempting to collect any debt owed on this account. This includes all attorney's fees, interest and late fees.

X-Rays:

- You are responsible to pay a \$20 fee for duplicate copies of your x-rays.

I hereby authorize payment to **Tooth Fixer Dental** by the group insurance, otherwise payable to me.

Signature of Patient or Responsible Party

Date