<u>Financial Policy</u>

WE NO LONGER ACCEPT CHECKS

This financial police is to help you understand the financial aspects of your visit to our office. Dentistry is no different than any other service oriented business. Payment is due when services are rendered. We do not participate with **<u>ANY</u>** insurance companies. Insurance estimates are presented as **"ESTIMATES ONLY"**. Fees are valid for 180 days, and are subject to change thereafter. If you provide us with your current insurance information, we will file claims to your primary insurance carrier for you. Our office will file with secondary insurance when your primary insurance has paid, and the account balance is paid in full. You are ultimately responsible for 100% of the entire amount of treatment completed if your insurance company fails to pay their portion.

Unlike medical insurance, most dental insurance companies have annual maximum benefits that significantly limit the amount of dental coverage especially if your dental needs are extensive. We have excellent relationships with many insurance companies but we have no what of knowing any limits you may have reached or any remaining balances that will be applied towards your deductible. Some insurance companies may dent benefits for routine dental procedures. If after 60 days, your insurance company has not paid your claim, we will forward the unpaid balance directly to you for payment. Upon receipt of insurance payment, any unpaid balance over 90 days will be sent to a collection agency. You will be responsible for any delinquent fee added to your account. Additional surcharges of up to 35% may apply. A $35 finance charge will be applied to any balance over 30 days. A $25 charge will be applied for checks with non-sufficient funds from pre- approved check payers. Cancellations without 24 hour notice will be subject to a **<u>$75 cancellation fee</u>** and a **<u>$150 cancellation fee</u>** *during* school holidays and breaks.

I understand that my insurance plan may not cover any part of the charges, costs, or expenses related to the dental treatment rendered and I will be responsible for all charges incurred.

I have read the above conditions of treatment and payment and agree to their content.

Name: ____

Signature: _____________________________________Date: _____/_____/______