Financial Policy Guidelines

You are entitled to a clear understanding of your financial obligations before treatment is rendered. A wide variety of services are available in this office, therefore, we do not have a uniform policy that covers all procedures and treatments.

PAYMENT IN FULL IS EXPECTED AT THE TIME SERVICE IS RENDERED. For your convenience, we do accept Visa, MasterCard, Discover, and American Express. We also offer Care Credit financing for qualified patients. **If time allows**, we will check your insurance benefits at time of 1st visit. On subsequent visits, for procedures that are a covered expense under your insurance contract, you will be required to pay the portion not covered by insurance. We do not determine the amount of coverage you receive from your insurance company. If your insurance company has not paid the balance of your account **within 45 days from the date of service**, you will have **15 days** to pay the balance. If your insurance company pays more than the balance due, we will send a refund check to you. You are responsible for any balance left after your insurance company has paid their portion. After completion of service, we will file your insurance for you and we will assist you in trying to receive maximum benefits.

If you want a **pre-determination of benefits**, please make this request at the time of your consultation as this takes time to receive.

Insurance is a contract between **you and your insurance company**. This office is NOT a part of this contract. We will file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding what the insurance considers as their "usual and customary charges", deductibles, co-payments, covered charges, or secondary insurance, other than to supply factual information as necessary to the insurance company. **You are ultimately responsible for the timely payment of your account.**

PLEASE BE READY TO PAY FOR TREATMENT WHEN RENDERED. You will be provided with an estimate of fees before the beginning of treatment. If you are unable to pay your portion of payment, we will schedule your treatment at another time.

Patients who schedule and then "break" their surgical appointment (without notifying the office at least 24 hours in advance of the scheduled appointment) will be charged a fee of $100.00. Therefore, please be kind enough to call us if you will not be able to keep your appointment.

I will be paying for today's visit by: _____ CASH _____CHECK _____CREDIT/DEBIT

By my signature, I have read, or have had this form read to me, and I understand the financial guidelines of the office.

SIGNATURE _____ DATE _____