FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. If you have dental insurance, we will file your claims as a courtesy to you. Dental insurance is a contract between you and your insurance company. It is your responsibility to understand the extent and limits of your coverage.

Any balance remaining not paid by your insurance company is your responsibility.

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

AT 30 DAYS
All accounts are payable by the patient/parent if insurance payment has not been received.
Further insurance appeal becomes the patients/parent's responsibility.
AT 90 DAYS
The balance will be tuned over to collection.
There will be $40.00 service charge for all returned checks.

APPOINTMENT POLICY

Because our office respects your time, we ask that you honor all appointments that you make in our office. If you must change an appointment, we request a **minimum of 24 hours notice**.

With adequate notice, we are able to help someone else during that time. Broken appointments with less than 24 hours notice will be assessed a $35 cancellation fee per child. your kind understanding.

After 3 broken appointments patient will be dismissed from the practice.

My signature below indicates that I have read and understand the financial and appointment policy as stated above and agree to accept responsibility as described, I understand that regardless of my insurance status, I am ultimately responsible for payment of my account.

____

(Name of Person Responsible for Bill) (Phone Number)

____

(Signature) (Date)

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I ______________________________ have received a copy of this office's Notice of Privacy Practices.

____

{Please Print Name}

______________________________ ______________

{Signature} {Date}