



## Financial Policy

Our office is committed to providing each patient with the best care possible. We have established the following guidelines to assist you in understanding our financial policy. We feel that a clear financial policy is very important in helping you obtain the service and quality you deserve.

1. Fees are quoted at the time of consultation or prior to treatment. Once a quote is given, the fees will not change except as follows:
  - a. If the patient's inability to keep an appointment results in prolonged and/or different treatment.
  - b. If the procedure becomes more complex due to undetectable decay or fracture.
  - c. Fees are valid for 6 months.
2. Payment is due at time of treatment. Although monthly payments are not accepted we do offer financing programs through Care Credit for treatment plans over \$1000. Please ask our team for information and an application.
3. Our office accepts cash, checks, MasterCard, Visa, Discover, American Express, and certain insurance plans.
4. We request 48 hours advance notice if you will be unable to keep your appointment. Should you fail to provide us with this courtesy we will charge your account \$84 for each scheduled hour. If you must cancel and have due cause we will not charge. initial \_\_\_\_\_
5. Returned checks shall be subject to a return check fee of \$28. initial \_\_\_\_\_
6. Balances older than 45 days shall be assessed a late payment fee of \$38. This shall be assessed at thirty day increments. initial \_\_\_\_\_
7. If it becomes necessary to take legal action to enforce this policy or to collect any fees for professional services rendered according to this policy, the patient and or financially responsible party shall be liable for all related costs and fees.

What is your preferred method of payment?

- Cash/Check     Visa     MasterCard     American Express     Discover

Card Number: \_\_\_\_\_ Exp. Date \_\_\_\_\_

Card Member Signature: \_\_\_\_\_

*My signature below indicates that I have read and understand the Financial Policy of this office.*

\_\_\_\_\_  
Signature of Patient and/or Financially Responsible Person

\_\_\_\_\_  
Date