FINANCIAL POLICY

Thank you for choosing us! We are committed to providing you with excellent service and treatment. The following is our financial policy which we ask that you agree to and sign.

1. Our practice is committed to providing the best treatment possible for our patients. Our diagnosis will always be based on what is in the best interest of our patients, not arbitrary insurance coverage or cost.

2. Our staff will inform you of your **estimated** share prior to beginning treatment. Please keep in mind that this is only an estimate, and may be subject to change.

3. **Payment in full is due at the time of service**. We accept cash, checks, Visa, Master Card, Discover and extended payment plans arranged upon request.

4. We may accept assignment of your insurance benefits. However, regardless of any insurance company's arbitrary determination of what is usual and customary, we do require that you pay your portion based on our fees at the time of service.

5. Please be aware that some, and perhaps all of the services provided may be "non-covered" and/or not considered "reasonable and necessary" under some insurance carriers. This does not negate your responsibility for the charges incurred. You as the patient are ultimately responsible for the entire balance for services rendered.

6. If your insurance company has not paid your account in full, the balance will automatically be transferred to you and will be your responsibility.

7. Once a statement is sent to you, a late fee will be charged every 30 days your balance is not paid in full. Any collection fees we incur will be transferred to you and become your responsibility.

8. Accounts with an open balance will require payment in full prior to scheduling any subsequent appointments.

9. **Appointment policy:** We request a minimum of 48 hours notice for any changes to a scheduled appointment. We charge $88 for broken/rescheduled hygiene appointments and $200 per hour for broken/rescheduled appointments with the doctors if a minimum of 24 hours notice is not given. Please help us serve you better by keeping your scheduled appointments.

I have read and agree to the above stated financial policy. I understand that I am responsible for keeping my appointments, and ultimately responsible for any charges that are incurred.

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| Signature | Printed Name | Date |