I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this form and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. **This information will be kept confidential.**

Patient/Guardian
Signature____Date___/___/___

Our financial policy is as follows:

We accept, CareCredit®, Sunbit, Visa, Master Card, American Express, Discover Card, personal checks and cash.

We will charge your account $35 for broken or no-show appointments with less than 24-hour notice.

Payment is due in full at the time of service, including insurance co-pay and patient portion.

We send insurance claims at the time of service. Your insurance policy is a contract between you, your employer and your insurance company. We bill them as a courtesy, we are not a party in your insurance contract.

All charges are your responsibility whether your insurance company pays or not. Not all services are covered by insurance.

If insurance has denied your claim, or not paid the estimated claim coverage after 60 days, the unpaid balance is considered your responsibility.

If a check payment is returned from our bank there will be a charge of $35.00 entered into your ledger balance.

Statements are sent monthly, and your balance is your responsibility. You will have a notice on your statement if your account is past due and being prepared for collection action.

There will be a finance charge of 27.5% of the unpaid balance added to any delinquent account. (90 days past due)

Our main concern is that you receive proper and affordable dental care, and to maintain your dental health. If you have concerns about our payment policies, please do not hesitate to contact our office.

We ask that all patients/guardians read and sign our Financial Policy. Thank you for entrusting us with your dental care.

Signature____Date___/___/___

Print name____