PHILOSOPHY

Your oral health is our top priority. We strive to provide you with the highest quality dental care available today. That is why we keep abreast of new dental techniques in order to continually improve our professional skill and judgment. More importantly, we are sensitive to our patient's feelings and encourage open communication about your dental needs.

FINANCIAL POLICY

An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. We will bill dental insurance, but you are expected to pay your estimated insurance co-payments for services rendered on the day of service unless prior financial arrangements have been made. Please contact the office for your available options. If insurance reimbursement is not received in the office within 45 days, you will be billed for the balance due. We cannot be responsible for actual payment made by your insurance carrier. Insurance estimates and pre-authorizations are not a guarantee from your insurance company. Your insurance policy is a contract between your employer and your insurance company and we are not a party to that agreement. Therefore, if treatment is dependent upon insurance coverage, we suggest you call your insurance company for an exact payment amount. We will be happy to assist in providing the necessary information you may need. After payments are received from your insurance carrier, you may be required to make additional payments or have a credit issued to you.

Accounts 30 days past due are subject to a minimum $2.00 service charge or 1.5% per month carrying charge on the existing balance. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. This practice will charge a $25.00 service fee on all returned checks.

APPOINTMENTS

We will attempt to address all dental emergencies promptly. Your comfort is of tremendous importance to us and we will do all we can to ensure this.

We would also like to make you aware that failure to keep your appointment, or cancelling without sufficient notification, which is at least 24 hours in advance, will result in the billing of a $50.00 fee.

I have read and understand the above information and will agree to the terms and conditions.

______________________________	______________________________
Patient/Patient Representative Signature	Patient Name (Print)
______________________________	______________________________
Relationship to Patient	Date