

**Method of Payment Agreement**

**Please take note that you are solely responsible for your account, not your insurance carrier nor any third party.**

As a courtesy to our patients, we offer several methods of payments. For your convenience, we:

- Bill your dental insurance on your behalf
- Accept, personal check, Visa, MasterCard, Discover, and American Express
- Offer dental treatment financing through CareCredit, Healthcare Finance

**It is the office policy that payment is due, in full, at the time of treatment.**

**If you have dental insurance, we will bill your insurance as a convenience to you.**

- Verification of dental coverage by our office does not guarantee benefits will be paid by your insurance provider.
- We will process your insurance claim, collect the funds from the insurance company, and apply payment to your account.
- Your coinsurance (set by your plan/group) is due at the time of service.
- Should your insurance provider not cover the full amount and there is a balance due, we will send you a statement that is due without delay.
- If we have not received payment from the insurance company within 90 days of your treatment, you will be billed the balance and your payment is due without delay.
- Interest will be charged at 1.5% per month for all accounts over 90 days old. If, after 90 days you have settled your account with us and we finally receive payment from your insurance company, we will promptly remit to you the insurance payment.
- Should your account be referred to an outside collection agency due to lack of payment, you are responsible for all fees associated with collecting the money owed.

**If you do not have dental insurance, payment is due, in full, at the time of treatment.** Again, for your convenience, we accept cash, personal check, Visa, MasterCard, Discover, American Express or one of three finance companies.

**Please select your method of payment:**

**Please bill my dental insurance, I will pay my coinsurance with,** Cash  Personal Check  Visa/MC  Discover  Amex  Finance Co.

**I do not have dental insurance. I will pay with:** Cash  Personal Check  Visa/MC  Discover  Amex  Finance Co.

I have read and fully understand the payment policy of this office. I have had all my questions answered to my satisfaction regarding the payment options available to me. I agree to the above information and terms.

\_\_\_\_\_  
Signature of Person Responsible for the Account

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**CANCELLATION POLICY**

There is a **\$50 cancellation fee** for all appointments that are “no show” (no call or pre-notification within 24 hours of your absence given to this office). This is necessary due to the high demand for appointments in our office. It is also a courtesy to notify us as soon as possible if you are not able to attend your appointment so that we may offer your appointment to other patients who may be in the need of emergency care or have been waiting for an appointment to come available. We understand that emergencies do happen and will do our best to work with you in those situations. If a patient has a strong history of “no show” appointments, we reserve the right to discontinue services, and will refer you to another provider. Please understand that this is in the interest of serving all of our patients in a timely manner.

I have read and fully understand the cancellation policy of this office. I have had all my questions answered to my satisfaction regarding the cancellation policy. I agree to the above information and terms.

\_\_\_\_\_  
Signature of Person Responsible for the Account

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date