the whole tooth
FAMILY DENTISTRY

OUR FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment.

PAYMENT RESPONSIBILITY
Payment is due at the time of service for all charges associated with your visit. In the case of a minor, the parent or guardian that accompanies the patient is responsible for payment. Unaccompanied minors must bring payment with them. A senior citizen discount of 10% will be given to those adults 62 years of age and over who do not have any form of insurance coverage.

METHODS OF PAYMENT
We accept cash, personal checks, or credit cards (Visa, Mastercard, Discover, or American Express). We also offer several payment plans administered through Care Credit – please ask for details if you are interested.

INSURANCE
As a courtesy to you, we will file your insurance claim with your insurance company and accept the benefit payment. The balance of your bill is your responsibility whether or not your insurance company pays a benefit on the services rendered. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. All deductibles and co-payments are due at the time of service. Our facility is committed to providing the best service for our patients and our fees generally reflect the usual and customary rates for our area. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary fees.

BILLING
A fee of $5.00 per month will be charged on all open accounts over 30 days old. Please be aware that in the event that your account remains open after 60 days, your balance will automatically be turned over to our professional collection company. Information will be given to the collection company and may include, but is not limited to: name, address, phone number, social security number, place of employment, and employment phone number. However, your medical/dental history will always remain confidential.

RETURNED CHECKS
A fee of $40.00 will be charged for any returned check.

MISSED APPOINTMENTS
Please help us serve you better by keeping your appointments. Kindly give 24 hours notice when it is necessary to cancel a scheduled appointment so that we may give your time slot to another patient awaiting treatment. We reserve the right to charge a fee of **$40.00** per missed appointment without 24 hr. cancellation.

Once again, we would like to thank you for the trust you have placed in us with your dental care. Please let us know if you have any questions about payment or financial responsibilities.

I have read, understand, and agree to the provisions of this Financial Policy.

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Signature of patient or responsible party Date