FINANCIAL RESPONSIBILITY & METHOD OF PAYMENT INFORMATION

1. Insurance – We will submit your insurance claims as a courtesy. If your insurance plan cannot be verified, then payment is required in full at the time of service. Knowing your insurance plan is your responsibility. Insurance benefit amounts are subject to final approval by your insurance company; therefore, the amount due at our office subject to change. All insurance benefits left unpaid after **30 days** are your responsibility. Payment will need to be made by you to our office within 45 days to avoid adding interest.
2. All patients must complete our patient information form before being seen by the dentist. We obtain a copy of your insurance and driver's license to provide proof of insurance and identity. If your insurance changes, please notify us before your next visit so we can confirm eligibility and make changes to your file.
3. If your insurance does not pay for your claim in 45 days, the balance will automatically become your responsibility. We will try our hardest to be your insurance advocate.
4. Credit balances will be refunded within 30 days when requested. The same method of payment (Visa, MasterCard, Discover, cash or check) will be used to process the reimbursement, according to the patient's original payment method.
5. There is a $30 returned check fee if your check is returned due to insufficient funds.
6. All records, x-rays, and photographs are the property of the office. A request for these records can be made, however an administration fee may be applied.
7. **MISSED OR LATE CANCELLED APPOINTMENTS WILL BE CHARGED $45 PER 30 MINUTES SCHEDULED** (60 minute appointment would be a $**90** charge). Appointments that must be cancelled/rescheduled, require a 48 business hour notice of the appointment to avoid any fees. We require the advanced notice so that we may offer that time to another patient. Please remember that this appointment time has been reserved for you.
8. **PAYMENT IS DUE IN FULL ON THE DAY OF TREATMENT.** Credit card payments (Visa, MasterCard, American Express, Discover and CareCredit) and cash/checks are accepted.

Please *initial* the following:

___________ **I authorize all dental treatment and assume all financial responsibility for all charges on my account. I authorize the release of payment from my insurance company to be made payable directly to the dentist.**

___________ **I have read the HIPAA Notice of Privacy and understand my rights as a patient as to how the office collects, protects, and discloses my personal information as provided by law.**

Signature: ____ Date: ___________________________

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