Financial Policy

We are pleased that you have selected us as your dental care provider. For your knowledge, our Financial Policy is outlined below. Please ask us, if you have any questions or need any clarification of this policy.

Promise to Pay. Amounts for dental care services provided to you or your family members may be charged to your Account, unless you specifically instruct us otherwise. You promise to pay us all amounts owed on your Account (your "Balance") under the terms of this Financial Policy when billed. If you have insurance, the amount you owe for services may be estimated based on the amount anticipated to be paid by your insurance company. We will assist you with an insurance claim; however, insurance is a contract between the policyholder and insurance company. The anticipated amount to be paid by your insurance company may be charged to your account until we receive payment from your insurance company. However, in the event your insurance company is slow to pay or disallows a claim, payment of your Account is your full responsibility. We may also charge to your Account fees set forth below for missed appointments, late payments, returned payments and/or collection costs. We will provide to you a statement (your "Statement") of your Balance, which will be payable when you receive your Statement. We may indicate on your Statement that your Balance is "pending insurance" and thus not yet payable by you. If you have insurance coverage, we may choose not to send you a Statement until we know or receive the amount reimbursable by your insurance company.

Missed Appointment Fee. We DO require 24 hour cancellation notice and we may charge to your Account fees for a missed appointment or fees for an appointment cancelled without 24 hour advanced notice. Fees range from $40-$100 depending on length of appointment with the Doctor or Hygienist. We try our best to stay on schedule and respect our patients' time and we expect the same courtesy from you, our patient.

Late Payment Fee. If we do not receive payment in full of your Balance within 30 days of the statement date shown on your Statement, you will be assessed a Late Payment Fee of 2.% of your unpaid Balance each month. We may not allow further appointments, unless in exceptional circumstances, until we receive full payment of your Balance.

Returned Payment Fee. If any check or other payment that you have made on your Account is returned unpaid, you will be charged a Returned Payment Fee, which is currently $30.00 and may be adjusted at our discretion.

Collection Costs. If we do not receive payment under the terms of this Financial Policy and we refer your Account to a collection agency or an attorney for collection, we may charge to your Account or otherwise collect from you our collection costs, including court costs and reasonable attorneys' fees, to the extent not prohibited by applicable law.

Credit Reports. We, or a collection agency or attorney acting on our behalf, may report late payments, missed payments or other defaults on your Account to credit reporting agencies. If you believe that we have information about you that is inaccurate or that we have reported or may report to a credit reporting agency information about you that is inaccurate, please notify us of the specific information that you believe is inaccurate by writing to us at the address on your account statement. NY Residents: Upon a written request we will inform you of the name and address of each consumer reporting agency from which we obtained a consumer report, if any, relating to you.

No Waiver by Us. We may waive our right to charge a fee to your Account without waiving any other right we have under this Financial Policy including our right to charge that same fee at any other time.

As used in this financial Policy, "we" "us" "our" and "Provider" mean the service provider named above. "Services" mean any services provided by us. "You" "your" and "Account holder" mean the person responsible for paying services. Payment for services is due when services are provided unless as noted otherwise above. By signing below, you are requesting that we establish an open account for you (your Account) as an accommodation to you for the tracking and payment of amounts due and you agree to the terms of this Financial Policy.

Yes, I agree to the above terms and conditions.

Account Holder's Signature Print Name Date

No, I am not interested in establishing an account and therefore understand that full payment for dental care services is due and payable by me at the time services are rendered.

Account Holder's Signature Print Name Date