FINANCIAL POLICY

We are dedicated to providing high quality care to our patients. Our goal is to help patients reach the highest level of oral health possible so they may enjoy the benefits of a comfortable, functional, and attractive smile.

PAYMENT POLICY

We pride ourselves on our patient-centered practice. Because of this we are committed to assisting our patients by offering the following payment options:

- Cash / Personal Check / Money Order
- Credit Card – We accept Visa, MasterCard and Discover
- CareCredit – A ***no-interest*** **monthly payment plan** that we offer as a separate line of credit to cover you and your family member's dental health needs.

Payment is expected at the time of your dental treatment. If the dental service is covered by insurance, we request that the estimated co-pay be made at the time of service. If this is not possible, please contact our business office *prior* to the scheduled appointment to discuss payment options.

DENTAL INSURANCE

It is important to remember that your insurance coverage is a contract between you, your employer, and your insurance company. As a courtesy to our patients, we will submit your dental claims to your insurance carrier. In order for us to provide this service, you must provide us with accurate and up-to-date insurance information. Please be prepared to present your insurance identification card at each visit. Any additional procedures required by your insurance carrier are your responsibility.

Your estimated co-pay amount is due at the time of service. We try very hard to keep track of individual insurance plans and the amounts they typically pay for procedures, however, plans routinely change and our estimate of your portion may vary from your insurance company's payment. When your insurance payment is received, any necessary adjustments in your balance will be credited (or debited) to you. All charges remain the responsibility of the patient, and any balance will be due in full 60 days from the date of service whether or not your insurance has made payment. **Reminder:** Many insurance companies require pre-authorization or second opinions. It is your responsibility to inform us *prior* to your appointment if a pre-authorization or a second opinion is required.

CANCELLATION POLICY

We realize that at certain times it may become necessary for you to change appointment times. ***We require that you notify us at least 24 hours in advance if you need to change or cancel your appointment time***. Failure to do so two times in a 12 month period will result in a $40 fee applied to your account.

This financial statement is provided to notify you of our policies as of the date of signature.

I have read and understand the above Financial Policy.

Signed ____ Date ___________

Nelson Family Dentistry
Rev. 11/01/2009