**Financial Policy**

2019

Please note that our office is a “FEE FOR SERVICE” office. Please be prepared to make all “co-payments” and payments on your account the day of your scheduled appointment.

**Missed Appointment Fees & Short Notice Cancelations*:******A $50.00 fee will be assessed for any short notice cancelation and or no show visit.*** We require a 24 hour notice on any appointment cancelation or reschedule to avoid this fee. No exceptions will be made to this policy. Please respect the fact that we are indeed an “office” and not a “clinic”. We have set aside time in our schedule for you specifically. Therefore, should you not come to an appointment you may have taken away time from a patient who has had a dental emergency occur. We make many attempts to confirm your appointment so you do not forget to avoid having to charge this fee.

**Insurance and Co-payment Information:**

**Insurance:** As a courtesy to you, our insured patient, we will bill your insurance on your behalf. Claims typically go out electronically at the end of every business day.

**Copayments:** Insured: We will collect any “estimated” co-payment at the date that treatment is rendered. In the off chance you have a payment plan established with our office, this will then be reconfigured to fit the financial agreement. (Care Credit)

We do our best to estimate your portion of out of pocket. In no way can we guarantee what your insurance will pay. This includes already pre-determined treatment. Your insurance policy is your alone. We will assist you should you need it in the chance of an insurance appeal on benefits. The account balance will need to be paid off and insurance can then reimburse you directly.

Non-Insured: Payments are always due at the time of service. We have payment plans available to you if this is a need. (OAC)

**FEES / INTEREST ON ACCOUNTS AND STATEMENT REBILL FEES:**

Accounts with a balance over 60 days will have interest charges and “rebill” your account fees assessed. Our Interest Rate currently is at 18%, equal to 1 ½ % of your account balance. A billing fee noted as a REBILL FEE on your statement is $5.00 and will be assessed monthly until the account has a zero balance.

**Returned Checks**: A $25.00 fee will be assessed

**Account Credits**: You can call for a refund if it is a true patient credit. Insurance refunds will be given as requested. You can also leave a credit for future treatment. You can build a credit on your account also for future treatment.

**Collection Accounts:** Automatic Dismissal from our practice as a patient will happen should your account go to Collections. All fees / Collection Costs are the responsibility of the account guarantor. Should your Collection Account be paid in full and you wish to return to our office as a patient ~ All monies will be due in full at every visit regardless of insurance.

Signature of Patient or Guarantor if minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_