



## Financial Policy

Thank you for choosing our practice to serve your dental needs. Please take the time to read the following, initial each section, and sign and date the bottom of this form.

\_\_\_\_\_ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

\_\_\_\_\_ Insurance balances are ultimately the patient's obligation. We will file with most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow-up with your insurance carrier to ensure proper payment.

\_\_\_\_\_ Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

\_\_\_\_\_ Patients are asked to confirm their appointments at least 24 hours in advance by directly contacting our office or responding to our confirmation emails/ text. Failure to confirm may result in loss of appointment time.

\_\_\_\_\_ There will be a fee of \$50 for failed appointments or those rescheduled without 24 hour notice.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Witness