# FINANCIAL POLICY –Terms & Conditions

(Please read carefully)

**Payment Options #1 (If you have NO Insurance):**

1. You choose to pay by ___cash, ___check, or ___credit card on the day that treatment is rendered.
2. On treatment involving fees (crowns, bridges, dentures, etc.) you may choose to pay 50% on the preparation date and the balance in three weeks.

**Payment Options #2 (If you have Insurance):**

1. You choose to pay your deductible f $___ and any out-of-pocket portions at the time services are rendered by ___cash, ___check, or ___credit card.
2. You choose to pay all of your treatment by ___cash, ___check, or ___credit card. We will request your insurance carrier send their payment directly to you.
3. On extensive treatment, (crowns or bridges) you may choose to pay 50% of your out-of-pocket portion on the start or preparation date, and the balance on the completion or delivery date. (Normally three weeks later.)
4. For visits under $200, payment is expected tat the time of service, regardless of Insurance. We will request your insurance carrier send their payment directly to you.

**Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charged to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

**Payments:** Unless other arrangements are approved by us in writing, the balance on your monthly statement is due and payable when the statement is issued, and is past due if not paid by the end of the month. There is a fee (currently $25) for any checks returned by the bank. We require a valid credit card number to remain on file in order to transfer any unpaid delinquent balance. Please fill in the following:

Account Number: _____ Exp. Date: _____

_____ Date: _____

Patient/Guardian/Cardholder's Signature

**Required Payment:** Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

**Waiver of Confidentiality:** You understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is report to a credit agency, the fact that you received treatment at our office may become a matter of public record. In addition, if we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs.

**Missed Appointment Fee:** Patients who do not show up on time for an appointment, or cancel with less then 24 hours notice will be charged a $20 fee. This fee must be paid before a new appointment is scheduled.

**Transferring of Records:** You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

**Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.