

## Patient Financial Policy

Your clear understanding of our financial policy is important to our relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility. Please remember that you are fully responsible for all fees charged by this office regardless of your insurance coverage.

Payment in full or your estimated patient portion is due at the time of services rendered.

As a courtesy to you, we will bill your insurance and accept assignment of benefits. Estimated benefits cannot be guaranteed. We make every effort to obtain your due benefits. However, if insurance benefits are not received within 60 days, payment is due from you.

Treatment involving lab work will not be sent to the lab until estimated portion is paid. Any remaining balance must be paid in full before final deliver of the case.

Treatment plans and the associated fees for treatment will expire in 90 days from when the plan was originally presented.

### Payment Methods:

We accept cash, checks, Visa, MasterCard, Discover and American Express. We also offer special financing through Care Credit.

### Returned Checks:

There will be a \$40 fee for any checks returned by the bank.

### Past Due Accounts:

If your account becomes past due, we will take the necessary steps to collect this debt. There will be a 1.5% (18% APR) on any balance 60 days past due. If we have to refer your account to a collections agency, you agree to pay all collection costs incurred.

### Cancellation/No Show- Fees

As a courtesy, we will make every attempt to confirm appointments. However, all appointments are your responsibility. All late cancellations and no-shows may incur a minimum **cancellation fee of \$75.00**. To avoid these fees, we required **48 hour advanced notice** if an appointment cannot be kept. Appointments scheduled Monday must be cancelled prior to 5pm on the Thursday before the appointment.

### Responsible Parties:

In situation of *divorce*, separation, court orders, etc., the party initiating treatment will be financially responsible for the account (including late cancels and no-shows)

All minors are required to be accompanied by a parent or legal guardian.

Patient Name (printed): \_\_\_\_\_

Patient Signature: \_\_\_\_\_