Dardenne
DENTAL ARTS

# FINANCIAL POLICY

Welcome! We would like to thank you for choosing us as your dental provider. It is our goal to provide you and your family with the best dental care possible. Our financial agreement is designed to show you your payment options as well as your financial responsibility for balances incurred for your health care in our office. We encourage you to ask any questions you may have regarding your treatment plan or the financial policy.

## PAYMENT IS DUE AT TIME OF SERVICE

Payment options: We accept CASH, CHECK, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS. We also accept CARE CREDIT as third party financing for an extended payment plan option with prior credit approval.

## INSURANCE

As a courtesy, we will submit all your dental claims to your insurance, but we do request you provide all of your dental plan information prior to your treatment. You are responsible for any balances incurred that your insurance does not pay. If your insurance company has not paid your claims within 90 days of your treatment, the balance will be transferred to your account and it will be your responsibility to try to collect. Every effort will be made on our part to collect from your insurance within a reasonable time frame. It is your responsibility to notify us of any changes with your insurance.

- We request that you give a 48 hour notice when you cancel an appointment. We will charge a $25 fee for both appointments cancelled without a 24 hour notice and failed appointments. Details posted in office.
- We will charge $30.00 for returned checks. You will no longer be able to pay by check in our office after two returned checks.
- There will be a 1.5% finance charge added to your account monthly for balances not paid within 90 days of treatment.
- All balances 120 days past due will be turned over to our collection agency with an additional charge of 40 % added to the balance.

I UNDERSTAND THAT PAYMENT IS EXPECTED WHEN SERVICES ARE REQUIRED. IF I DEFAULT IN PAYMENT AND COLLECTION IS REQUIRED, I WILL BE RESPONSIBLE FOR ALL COLLECTION AND/OR ATTORNEY FEES AND COURT COSTS.

I have thoroughly read and agree to the terms of this financial policy.

_____
Print Patient Name

_____ _____
Signature Date