We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. For your convenience we accept cash, check, Master Card, Visa, Discover, American Express and Care Credit. A service charge of 1.5% monthly or 18% annually may be charged on accounts exceeding 90 days, unless previously written financial arrangements are satisfied. All accounts 90 days past due will be considered delinquent and will be reported to Action Collection Service.

Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance. Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. If cancellations within the 24 hour period occur, or, an appointment is failed without notice, a $25 fee may be charged.

Insurance Explanation

Your insurance policy is a contract between you and your insurance company, the doctor is not involved. As a courtesy, we bill your insurance plan directly. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly.

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list); however, we are not preferred providers with all of the ones we accept. It is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.** If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket figures you may require.

I hereby authorize payment from my insurance company to the dentist or group listed below. * I understand I am responsible for all charges whether or not paid by insurance. *

Refunds

If your estimated patient portion results in a credit to your account you may leave the credit on file for future dental visits or we will gladly refund any requested credits. Please allow up to 14 business days to process your request.

Signature: _____ Date:_____

Parent (If Minor): _____ Date:_____