Policy Concerning Payments & Insurance

Our office wants all of our patients to comfortably afford dental care. Part of our commitment to you is to help contain the ever-rising costs of care. With this in mind, we proudly offer the following financial policy so that our patients can have the opportunity to decide which payment option best suits their needs.

As a courtesy to you, we will bill your insurance for you and assist you in receiving your maximum allowable benefits. We do not determine your coverage or benefits. All charges are your responsibility whether you have insurance or not.

If you do not have insurance, your charges will be due at the time of service. We accept cash, check, MasterCard, Visa, Discover, American Express and CareCredit.

If you have dental insurance, your estimated liability will be due at each scheduled visit. We will estimate your coverage, but until we actually receive the payment from your insurance company, it is just an estimate. Our estimates are subject to final approval by your insurance company and could therefore change the amount due to our office. If we need to bill you for services not covered by your insurance, they will be due upon receipt of statement and subject to a $15 late fee if not paid in full within 3 weeks of your visit. Please be advised that you are responsible for payment of all treatment, late fees and collection costs if necessary. A 18% APR will be charged to all past due accounts.

Outside dental financing is offered through CareCredit. This is offered to patients needing extended payment options. Financing treatment allows you to start your dental care immediately and spread payments over a period of time. You will make payments directly to the financing company and they will pay us for treatment. Qualification is simple and quick. This is an interest free option and can be further discussed with our financial coordinator.

We would be happy to work with you to plan the most appropriate arrangements for your budget. We encourage you to contact us promptly should a temporary financial problem arise that may affect payment for your visit. Most importantly we want you to enjoy the benefits of your dental health without the financial strain. We appreciate your trust in us and the opportunity to serve you.

I have reviewed the above and understand that I am responsible for all treatment expanses that I occur.

Signature _____ Date _____