Method of Payment

1. **Payment is due at time of service. If you have dental insurance, you will be responsible for your co-payment and deductible (if any) at time of service. Should you not be prepared to pay your entire balance at time of treatment, please advise the staff PRIOR to treatment so that financial arrangements can be completed.**
2. We accept cash, check, money orders, debit cards, Master Card, Visa, American Express, or Discover for payment.
3. For larger treatment plans, 3rd party financing including CareCredit, Dental Fee Plan, and Citi Health Card may be available to you through this office. Please speak with the Office Manager for more information concerning these options.

Dental Insurance

1. **Your dental insurance is a contract between you, your employer, and your insurance company.** As a courtesy, we will submit your dental claims to your insurance company. **You will be responsible for your estimated co-payment and deductible at time of service. (This is only an ESTIMATE which may vary when we receive payment from your insurance company.) If your claim has not been paid within 90 days of submission by this office, you will be responsible to pay the balance of the claim.** We will assist you, to the best of our ability, in being reimbursed by the insurance company for that payment.
2. **Not all treatments are a covered expense by your insurance.** We will do our best to maximize your insurance benefits and minimize your out-of-pocket expense.

Related Financial Information

1. **Returned checks will result in a $35.00 charge to your account.**
2. **In the event that the account is not paid and we refer the account to a collection agency, you will be responsible for all fees incurred for the collection of your bill (i.e. attorney fees, court costs, and the collection agency fees).**
3. Your appointment time is reserved exclusively for you. **Any change in your appointment affects many patients, thus, a 24 hour notice is required. Anything less than a 24-hour notice is subject to a $35 per ½ hour missed appointment fee that will be levied at the discretion of the staff.**

I have read and understand the above information. I understand that I am responsible (regardless of my insurance) for any charges or fees incurred from services rendered.

Signature ____

(Please continue on other side)