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Office Financial Policy

In an effort to prevent any misunderstanding, we have set forth this financial policy.

1. Full payment is expected at the time of service unless other arrangements are made.
2. When major services that involve lab work are performed (i.e. Crown, onlays, dentures, etc.), 50 percent is due upon preparation, and the balance is due upon insert.
3. A service charge of 1.5 percent per month on the unpaid balance will be charged after 30 days.
4. If an appointment is broken or cancelled with less than 24 hours notice, a charge of \$25.00 will be applied to your account.
5. Returned checks are subject to a \$20.00 service charge.
6. It is understood and agreed that in the event that any outstanding balance has to be referred to a collection agent or attorney for recovery, the patient will be fully responsible for any costs, including but not limited to attorney's fees.

Print full name of each member of your family that you are responsible for below:

Please sign below to indicate that you have read and fully understood said policy.

SIGNATURE

Please fill out the following information if you have Dental Insurance

(Make sure that all information is complete. It will greatly expedite the processing of your claim. Thank you.)

Name of Insured _____ Insured's Date of Birth _____

Insured's Social Security Number or Insurance I.D. Number _____

Employer _____ Employer's Phone number _____

Employer's address _____ City _____ State _____ Zip _____

Insurance Company _____ Insurance Co.'s Phone number _____

Insurance Group # _____

Insurance Co.'s Address _____ City _____ State _____ Zip _____

What is your yearly maximum? _____ What is your yearly deductible? _____

What percent does your plan cover for?

Preventative services _____ Basic services _____ Major services _____