OFFICE FINANCIAL POLICY

It is our policy to discuss treatment plans with all patients or guardians before dental treatment.
A complete estimate of fees and method of payment will be discussed after the initial consultation.

Dental Insurance:

We are happy to cooperate with individuals who are covered by dental insurance. We only ask that you carefully read your policy to be sure that you are fully aware of any restrictions that apply to benefits provided. Dental insurance is a contract between the patient and the insurance company.

To prevent any misunderstanding concerning dental insurance payment, the following policy has been established.

1) Payment must be made as treatment progresses and surgery must be paid in full one (1) week prior to your scheduled treatment date.
2) We will complete and mail your Dental insurance forms for you; however, please keep in mind that you are responsible for payment for services rendered.
3) A pre-treatment estimate form can be submitted to your insurance company for authorization of benefits prior to treatment being started. Note that it may take 4-6 weeks for a reply from most insurance companies.

PLEASE NOTE:

Predeterminations are not a guarantee of payment. It is the patient's responsibility to know how much of their yearly benefit is remaining for the year. Most insurance companies have websites for your convenience to access what benefits you have used and have left for the year.

Method of Payment:

1) Full payment at each appointment is expected in the form of cash, check, credit card (Visa, MasterCard, Discover, Debit, American Express, Wells Fargo, or Care Credit).
2) If you need to make payment arrangements, please contact our Financial Coordinator for information on financing through Wells Fargo or Care Credit.

Interest charges of 1.5% per month are placed on the account if payment is sixty (60) days past due.

Cancellation Policy:

THERE WILL BE A $250.00 CHARGE FOR ANY SURGICAL APPOINTMENT CANCELLED WITHOUT ONE (1) WEEKS NOTICE. THERE WILL BE A $50.00 CHARGE FOR ANY HYGIENE APPOINTMENT CANCELLED WITHOUT 24 HOUR NOTICE.

I have read and understand my financial responsibility at Dental Implants and Periodontal Health of Rochester. If my account goes past due ninety (90) days, I understand that I will be responsible for any charges associated with collection proceedings.

Patient signature _____ Date _____