FINANCIAL AND DENTAL BENEFITS POLICY

Thank you very much for choosing our office to serve your dental needs. Claims for your Dental Benefits are filed on behalf of our patients to your primary Dental Benefit Carrier. As a courtesy to you, we will gladly process your Dental Benefits. However, if a claim is not paid in full by your Carrier, **the balance is your responsibility.** The benefits belong to you, and are an agreement between you and your Dental Benefit Carrier. There are **NO GUARANTEES** of benefits from your Carrier until the claim is processed and paid.
THEREFORE, ANY AMOUNT QUOTED TO YOU BY OUR OFFICE REPRESENTATIVE IS ONLY AN ESTIMATE AND ANY REMAINING BALANCE AFTER YOUR CARRIER HAS PROCESSED THE CLAIM IS YOUR RESPONSIBILITY. _____ (**initial**)

Payment is due at the time of service for all procedures. If you have Dental Benefits, your **estimated** portion is due at the time treatment is started. It is our office policy that patients pay for their portion in full and we will file a claim to your Carrier for their estimated portion. For your convenience, we accept cash, checks, Visa, Mastercard, Discover, and American Express. Please feel free to discuss any financial concerns PRIOR to being seen for the procedure.

Please provide us with a copy of your Dental Benefit card so that we may file claims on your behalf. If you do not have a card, please provide all the information below for your Dental Benefit Carrier as well as the policy holders information. If we are not provided with correct information for your Carrier, you will be responsible for the charges incurred at the time of service.

Policyholders name_____ DOB_____
SS# or ID#_____ Group#_____
Employer_____
Dental Benefit Carrier Name:_____ Phone#_____

CANCELLATION POLICY

Regarding appointments, we have reserved a spot specifically for your dental treatment. Please be advised that we require **a minimum of 48 hours** to cancel or change an appointment. **You will be charged a $50 fee if 48 hours notice is not given to cancel or change your appointment. _____(initial)**

Signature:_____ Date:_____