Financial Policy

Please read and sign the acknowledgement of the policy below

If you wish, please ask for a copy of this policy for your records

We realize that every person's financial situation is different. For this reason we encourage you to communicate your financial needs in order for you to receive the best dental care and to enjoy a healthy and confident smile.

Since we know it is not always possible to pay your dental bill in full, we ask that you discuss financial options when you receive your treatment estimate, not after the procedures have been done. The front desk will be happy to speak with you!

For larger treatments, we are happy to have partnered with Cherry! Cherry is a leading patient "buy now, pay later" option that makes it easy to spread your payments out over time. Cherry can potentially be a low to no interest payment plan that does not affect your credit score to apply! Please ask the front desk about this amazing financial opportunity!

Our fees reflect our commitment to the quality of care that our patients deserve. If you have insurance, we will be happy to assist you in processing your insurance claims to maximize your benefits. Please note that if insurance does not process the claim in the appropriate amount of time, the full balance may be your responsibility. Insurance is designed to help offset the cost of your dental care. Insurance estimates provide a table of allowances that will assist you in determining your approximate out-of-pocket expenses.

It is the patient's responsibility to know their benefits. This includes but is not limited to, remaining maximums, limitations, waiting periods, missing tooth clauses and frequencies of services. As a courtesy, we do our best to know this for you but cannot guarantee 100% accuracy. Treatment estimates are based on your current insurance plan and are estimates only. Final determination is made by your insurance company. Please note that the estimated copayment and deductible will be expected at time of services.

I have read and fully understand the financial obligations. I understand that in the event my account becomes delinquent I will be responsible for any collections, attorney fees, court costs and any other charges incurred to collect the account.

Printed Patients Name: ____ Date: ______________________

Signature of Patient or Authorized Representative: ____