Our Financial Policy

Our practice is a "fee for service" practice. This means that payment is due at the time that treatment is rendered. Our office offers a variety of methods of payment: Care Credit, Visa, Mastercard, Discover, American Express, cash, and checks.

Our office will provide a "walk-out" statement for you to file with your insurance company in order that you might be reimbursed.

As a COURTESY to our patients, we accept assignment of benefits, when "fee for service" is not possible. THIS MEANS: we file most insurances; we await payment on the portion of your bill for which the insurance company is responsible. When this occurs, patient MUST PAY the portion not covered by the insurer at the time of service. This is know as the "co-payment."

When using dental insurance in our office, please provide the following:

1. A current I.D. card identifying your group# or employers name, employee's ID number, current mailing address and telephone number for verification.

2. When covered by two or more policies, this must be made known at the time of service in order that a proper coordination of benefits can be made.

YOUR RESPONSIBILITY

1. In the event that your insurance does not pay the expected amount, you , the patient are the responsible party. Account balances are due within 30 days of receipt of your billing statement.

2. If your account is in dispute, contact our office immediately. Account balances over 90 days past due are referred to an outside agency for collection.

DIRECT REIMBURSEMENT: There are insurance companies that do not reimburse our office, but instead reimburse or pay the patient. In these cases, YOU are a "fee for service" patient and full payment is due at the time of service. Our office will generate a claim after receiving payment in order that you might be reimbursed directly by your insurer.

In addition, if insurance coverage cannot be verified for you, YOU are a "fee for service" patient in our office and after receipt of payment, a "walk-out statement"/ claim will be provided for reimbursement by a third party/insurer.

Signature_____ Date_____