Financial Policy

It is our goal to keep prices as low as possible. If you have insurance, we will file it for you as a courtesy. If you do not have insurance, we accept cash and all major credit/debit cards. We will accept checks only from established patients.

Regarding Insurance:
Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We accept assignment of insurance benefits after you furnish us with your full insurance information and this is verified by your insurance carrier. Your deductible and patient portion are due at the time of service. Some of the services provided may be a non-covered service and not considered necessary by your dental carrier. You are responsible for payment of any insurance company's arbitrary determination of usual and customary rates. If the patient is a minor, the adult accompanying a minor patient is responsible for payment in full.

Assignment of Insurance Benefits:
I hereby authorize payment directly to **Art of Dentistry** and its dental providers for the dental service benefits otherwise payable to me.

I understand that, although **Art of Dentistry** will do all that is in their power to present to me estimates that are as accurate as possible, any quote given to me, in person, in writing, over the phone, or in any form of communication used by **Art of Dentistry, PLLC** will only be an estimate based on the information provided to them by my insurance carrier.

I understand that if performed dental services are not under contract with my insurance carrier or I have met my contract limitations, I am responsible for payment of the full balance due.

Missed Appointments:
Your time is valuable. That is why we strive to see you in a timely manner. The time of your dental provider, as well as other patients' time, is also valuable. In order to respect this, we kindly ask that you give us a **24-hour advance notice** for any cancelled appointment. Once two scheduled appointments have been missed without the requested advance notification, we reserve the right to allow only same-day appointments. We also reserve the right to deny any future scheduling of appointments due to repeatedly missed, cancelled, or late appointments. In the latter case, you would be notified of such action and given 30 days to find another provider.

Unpaid Balances:
If your account becomes past due, we will take necessary steps to collect this debt. I understand that any attorney fees, court costs, and collection fees become my responsibility and will be added to my account, should it become necessary. Returned checks will be subject to a $25.00 fee per occurrence. Finance charges of 1.5% per month may be imposed on the unpaid balance after your account has gone 30 days past due.

Credit History:
If your account were to become past due, we have the option to check your credit history and to report your account history to any credit reporting agency such as a credit bureau.

ACKNOWLEDGEMENT OF RECEIPT
I acknowledge that I have read in its entirety and agree to the above Financial Policy.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Print Name Relationship to Patient