

FINANCIAL POLICY

Thank you for choosing us as your Dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our Patient information sheet before seeing the doctor.

AS OF OCTOBER 1, 2006 FULL PAYMENT OR COPAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AND DISCOVER CARDS.

Usual and Customary Rates (UCR)

Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. Please be aware that some and perhaps all of the services provided may be "non-covered". You are responsible for payment in full regardless of any insurance company's arbitrary determination.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Your treatment will be more effective if you follow your doctor's guidelines and stick to your treatment schedule. Please help us to serve you better by keeping scheduled appointments.

Thank you for understanding our **Financial Policy**. Please let us know if you have any questions or concerns.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY

x _____ DATE _____
Signature of Patient or Responsible Party

A photocopy of this form shall be considered as effective as the original.