# Financial Policy

Thank you for choosing Dental Horizons. Our primary mission is to deliver the highest quality and comprehensive dental care available. Animportant part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by clarifying financial responsibilities in advance. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment.

## AGREEMENT

Dental Horizons fees reflect our commitment to the quality of treatment and materials our patients deserve. We require payment in full at the time of service. If you have dental insurance, we require payment of your estimated portion for services provided that day. For your convenience, we accept cash, personal checks, Visa, MasterCard, Discover, American Express and Care Credit.

**BillingStatement:**The balance on your statement is due and payable when the statement is issued unless other arrangements have been approved. Balances older than 30 days will accrue interest at the rate of 0.67% per month.

**Missed Appointment Fee:**Patients who do not show up for an appointment, or cancel with less than 24 hours notice, may be charged a **$65.00** fee.

**Returned Check Charge:**Dental Horizons charges a **$30.00** fee for returned checks with non-sufficient funds.

**Past Due Accounts:** If your account becomes past due, we may take necessary steps to collect this debt. If a collection agency or attorney must be used, you agree to pay all of the collection costs, attorney's fees, and court costs associated with the collection.

## INSURANCE

Your insurance policy is a contract between you and your insurance company. You are the responsible party for payment of services provided whether your insurance company pays or not.As a courtesy to our patients, we will be happy to file the claim for your dental benefits from your dental insurance. However, if we do not receive payment from your insurance carrier within 45 days, you will be responsible for payment of your treatment fees and collection of your benefits from your insurance carrier. Ultimately, it is the patient's responsibility to keep up with all of their insurance benefits and any changes. We cannot and do not guarantee payments from insurance companies and patients are expected to pay their estimated percentages and deductibles at the time their treatment is rendered.

## MINORS

The parent(s) or guardians accompanying a minor are responsible for the payment. Minors must be companied by a parent or legal guardian to receive treatment.

We are committed to providing excellent dental treatment to all of our patients. By signing this agreement, you are agreeing to all of the terms and conditions explained above. Please let us know if you have any questions.

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Patient, Parent, or Guardian Signature Date

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Patient Name (Please Print)