



Financial Policy

Thank you for choosing **Dental Horizons**. Our primary mission is to deliver the highest quality and comprehensive dental care available. An important 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, and Care Credit.

Billing Statement: Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued and is past due after 30 days from statement date. Balances older than 30 days will accrue interest at the rate of 1.5% per month or 18.00% per year.

Credit History: If written financial arrangements are made, you give Dental Horizons permission to check your credit history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency or credit bureau.

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. This fee must be paid before a new appointment is scheduled.

Returned check charge: Dental Horizons charges a \$35.00 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 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. We are not a party to that contract. We cannot compromise on your care, but we can do our best to help you get the benefits you deserve. Our office is obligated to provide you with the treatment you need, but your insurance carrier is only obligated to pay for what your policy calls for. 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 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 accompanied by a parent or legal guardian to receive treatment.

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

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)