

First Choice Dental Care Financial Policy

Thank you, for choosing 1st Choice Dental Care to provide your dental health. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require that you read sign prior to any treatment.

- Full Payment is due at the time of service
- We accept Cash, Check, Care Credit, Visa and Master Card
- Cancelled or Failed appointments with **less than 48 hours notice**
- A **\$25.00** fee will be charged to your account

Regarding Insurance:

You are required to pay the deductible and % that your insurance does not cover at each visit. We do accept assignment of insurance benefits and will be happy to submit a claim to your insurance company for you. We cannot bill your insurance company unless you bring **ALL** insurance information and if needed an original claim form. Your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract. Our office strives to provide quality dependable, and esthetic dental care. The "least expensive" insurance solution is seldom in the best interest of the patient's health. It is important to understand that insurance companies draw a contract with the patient's employer.

Their plan may not fit your overall health requirements. They can and do apply clauses that limit their level of coverage, placing sole responsibility on the patient. **ANY** balance owed after insurance pays, is **your** responsibility. Please be aware, some and perhaps all of the services provided may be non-covered services under your insurance policy. Also keep in mind some procedures have restricted frequencies, as to how often they can be performed. The insurance company is not competent to diagnose, but they can apply their rules to the policy. Payment denial reflects only the insurance company's resistance to pay and not lack of need for rendered treatment. **Full payment is still required.**

Please be advised there is a \$40.00 return check fee, for all checks returned.

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

Signature or responsible party: _____ Date: _____