



We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

We realize understanding your insurance coverage can be quite challenging. We do our best to verify your eligibility and benefits prior to your visit. **This is not a guarantee of payment.** Unfortunately, detailed information is not always disclosed by your insurance company. We encourage you to become familiar with your policy's exclusions, deductible, frequency limitations and required coinsurance if any.

Payment is due at the time of service; we accept Cash, Checks, Care Credit, and all major credit cards. Keep in mind that your insurance policy is a contract between you, your employer and your insurance company. We will **estimate** your portion due prior to treatment based on information obtained from your insurance company. As a service to you, we will file a claim on your behalf. Please understand after your insurance processes your claim there may be a remaining balance left on your account. **The remaining balance is due and payable at that time.**

If your insurance has not paid us after 60 days, the balance will be transferred to you for payment. If at a later date we receive payment from your insurance company, any overpayments can be applied toward future visits or refunded to you.

Scheduling and Cancellation Policy

To schedule a treatment appointment with the Doctor you will be required to pay a portion of your estimated amount due for the treatment at the time of scheduling.

We offer 7:00am appointments. To schedule at this time a \$35.00 deposit is required to reserve. Your deposit will be applied towards your treatment or refunded if your insurance covers all of the treatment.

Please call us by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 10:00 a.m. on Friday. **If prior notification is not given, you will be charged \$35.00 for the missed appointment.**

I have read and understand the above financial and scheduling policies and I agree to be bound by its terms. I also, understand and agree that such terms may be amended by the practice from time to time.

Patient name

Signature of patient/parent

Date