Financial Policy

As validated by my signature on the bottom of this form, I understand and agree that: All patient balances are due immediately after treatment is rendered. Please ask us if you are interested in learning about third party financing, which may allow you to finance your treatment in low monthly payments.

Should a balance accrue on the account a statement will be sent and payment is to be made, in full, by the date on the statement. If Payment is not paid within 30 days interest may be applied to the entire account balance. A revised statement with the new account balance, payable immediately, will be sent.

A returned check fee may also be applied and must be payable from you for each check payment returned to us by your bank.

Dental Insurance is a contract between the patient, the employer (if applicable) and the insurance company. Submitting claims for payment to the insurance company is a courtesy provided by the dentist, not an obligation. Predeterminations from my insurance companies are NOT a guarantee of payment. I understand the clinic has established the patient balance based on the information I have provided. Final treatment payment is subject to the terms and conditions of my insurance provider on the date of service. As such, until payment is received from my insurance provider, no patient payment is ever final. Ultimately, I am responsible for any treatment that is unpaid by insurance.

Estimates and treatment plans are based upon information gained from the examination. As with any dental treatment, there may be unforeseen treatment adjustments. This is a preliminary estimate only and lab charges (if applicable) have been estimated and included in total. The clinic will make an effort to anticipate any changes in the treatment plan and advise me at that time. However, such events are unpredictable. Likewise , the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

Estimates do not take into consideration any money that was billed toward my insurance maximum and treatment limits that may have been used at other dental clinics.

Our dental office will make every effort to accommodate my scheduling needs.

I have read, understand and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all fees for services rendered to me and or my family.

_______________________________________ ______________

Signature Date

123 Little Spring Road, Blowing Rock, NC 28605 828-295-9603