# FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. Our goal is to provide you and your family with optimal dental care. We believe that all patients deserve the very best dental care we can provide. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. We also believe that everyone benefits when specific financial arrangements are agreed upon. 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 and sign prior to any treatment. All patients must complete our New Patient information forms before seeing the doctor and update them yearly.

**PAYMENT IN FULL IS DUE AT TIME OF SERVICE.WE ACCEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER.**

## FINANCIAL AGREEMENT

Patients are expected to pay for services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-payment, deductible and any services not covered by your insurance at the time of service. If an overpayment occurs, you can choose to keep it on your account for future use, or we can issue you a refund. Refunds will be issued once a month.

## OPTIONAL PAYMENT TERMS FOR NON-INSURED PATIENT

Full pay cash discount: We offer a 5% accounting courtesy for all Dr. provided services over $500 that is paid in full prior to the commencement of services. This discount is not extended to hygiene services.

There will be a fee for any additional procedures NOT included in the original treatment plan. Dr. Burtwistle will inform you of any required adjustment to your treatment.

## REGARDING INSURANCE

We request that any estimated co-payment, deductible and any services not covered by your insurance be paid at the time services are provided. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you provide us the proper insurance information at your initial visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance has not paid your account in full within 90 days, the balance will be automatically transferred to your account. Please be aware some and possibly all of the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of your dental insurance policy. We file your insurance claims as a courtesy.

**Dr. Burtwistle will diagnose treatment based on your dental health, not your insurance coverage.**

## MISSED/CANCELLED APPOINTMENTS

**Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $25.00 per ½ hour for the duration of your reserved appointment time.** Please understand that missed appointment times are valuable to those patients that may find it hard to come to the dentist other times.

We respect our patient's time, and we request the same respect of our time. Please help us serve you better by keeping your scheduled appointments. Excessive cancellations and no shows will result in us placing you on a short call list, which means we will phone you when an appointment time becomes available on short notice.

## COLLECTIONS

Any account that has not received payment in 90 days will be handed over to a collections agency that will pursue the responsible party for reimbursement. This will negatively impact your credit history, and severely limit the treatment you can receive at our office. You will also be responsible for all costs of collections, inclusive of legal fees that we may utilize in trying to recover the cost of treatment.

**Please indicate your understand and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.**

Patients name (please print) Date

Patient (or parent) signature Date

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