Joyful Dental Care

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FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. 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 you to read and sign prior to any treatment.

We accept CASH, CHECKS, CARE CREDIT, VISA, MASTERCARD and DISCOVER.

The adults accompanying a minor and the parents or guardians of the minor are responsible for insurance coverage or full payment. For unaccompanied minors, non-emergency treatment will be denied unless insurance coverage has been verified or charges have been pre-authorized to an approved Care Credit plan, Visa, MasterCard, Discover, or payment by cash or check at time of service has been verified.

Insurance

Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable, customary or necessary under your insurance benefit plan.

Patient or Guardian Name (Printed): _____

Patient or Guardian Signature: _____ Date: _____

Missed Appointments

Unless cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. This charge is the sole responsibility of the patient and will not be billed to the insurance carrier of any other third party.

Patient or Guardian Name (Printed): _____

Patient or Guardian Signature: _____ Date: _____

Finance Charge/Interest

A finance charge of 1.25% per month will be added to account balances 30 days or more past due. We reserve the right to charge interest in the amount of 18% as provided by state law.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Patient or Guardian Name (Printed): _____

Patient or Guardian Signature: _____ Date: _____