ALBANY DENTAL CARE

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best care possible. The following is a statement of our financial policy which we require you to read and sign prior to any treatment. All patients are required to complete our patient information forms before being seen by the Doctor or Hygienist. (Please initial each line after reading):

_____We accept the following forms of payment: Cash, Check/ Money Orders, All Major Credit Cards, Care Credit (the card and person whose name the card is in must be present).

_____Payment is due in full at the time of service.

_____The parent (guardian) that accompanies any minor child/children to their appointment is responsible for any payment due.

_____Checks that are returned to our office from your financial institution are subject to a returned check fee based upon what our bank's charges are.

_____In order to reserve appointment time in the Doctor's schedule a "deposit" is required. This amount will go toward the cost of your treatment. The amount of the "deposit" is based on the length/ type of treatment you are having performed.

_____There are no refunds for dental services that have already been provided.

_____If you miss or fail to show for an appointment there may be a fee charged to your account.

REGARDING DENTAL INSURANCE

_____Your complete dental insurance information must be presented at the time services are provided if you would like us to submit your claims for you.

_____We are "out of network" with all dental insurance carriers. Payment is due in full on the date of service.

_____Your dental insurance policy is a contract between you and your insurance company. It is your responsibility to know your maximums, dental coverage information and deductible information. It is essential that you understand your specific group's dental coverage. You are ultimately responsible for all services regardless of coverage.

_____All accounts carrying a balance longer than 90 days will be notified of their account being transferred to an attorney for collection proceedings. You are liable for any amounts charged by the attorney.

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

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE