Autumn Ridge Dental

Financial Policy

We are so pleased that you have chosen our practice to take care of you dental needs. We will do our very best to give you the most excellent dental care available. It is very important to us that we earn your trust.

So that we can prevent any misunderstanding and maintain a positive relationship with you, the following is the practice's financial policy. We thank you for your understanding and cooperation with these policies. After having read the policies, please sign at the bottom.

- **Payment due at the time of service** – We require that you pay on the date that the services are rendered (this includes children who drive themselves or are accompanied by another adult). We accept cash, checks, credit cards, and debit cards. We also accept CareCredit. Any balance not paid in full will be subject to a monthly finance charge.
- **Insurance Patients – Autumn Ridge Dental is an "<u>OUT OF NETWORK PROVIDER</u>" -** Patients who are fortunate to have dental insurance coverage will be required to pay their estimated co-payments at the time of service. A copayment is the amount that insurance does not pay based on the percentage of fees covered by the plan, the usual and customary fees that the insurance company follows, deductibles, and plan maximums. You will be responsible for paying fees in full when a claim is still unpaid after sixty (60) days.
- **Returned Checks** – If any checks are returned by the bank, we require that the check be immediately reimbursed in cash. A $25.00 returned check fee will be charged to your account. Your account will then be placed on a cash only basis.
- **Finance Charges** – Any balance that is accrued over 90 days will be charged a finance charge of 1.5%.
- **Broken Appointments** – We require that at least a twenty-four hour notice be given on appointment cancellations. If an appointment is cancelled in less than twenty-four hours or is broken it will be considered a "No-Show". Patients who have three "No-Show" appointments may be dismissed from the practice.

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Patient **OR** Parent/ Guardian Signature Today's Date