Life Long Dental Care

Financial Policy

Welcome! Thank you for selecting us as your dental care providers. Our goal is to provide you and your family with optimal dental care at an affordable cost. 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. This includes understanding your treatment plan as well as our financial policy.

Financial Agreement:

Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payments may be made using cash, check, Visa, Mastercard and/or Discover. We also offer Care Credit, which is a financing option that is available only for healthcare expenses. Outstanding balances after 90 days will be subject to an 18% annum charge.

Appointments:

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. Twenty- four hour notice period is required for any cancelled appointment. Cancellations without the required notice period will be subject to a $50.00 broken appointment fee placed on your account.

Insurance Information:

As a courtesy to our insured patients, we submit claims to your insurance company on your behalf. On your first visit and annually (based on your insurance company's calendar) please present your insurance card and/or insurance policy. In the event that your insurance company does not cover a portion or all of your services or down codes the treatment performed, you will be responsible for the full balance.

If your insurance has not paid within 90 days, full payment is expected for services rendered. Should the insurance company pay your claim to our office after the 90 days a reimbursement check will be sent to you for the appropriate amount by LLDC.

Please indicate your understanding 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 shall also cover your dependent children who are patients of the practice.

_____ _____

Patient Name Date

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Patient Signature