FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. I understand that charges for care rendered to me will depend on what treatment is necessary to provide appropriate and quality dental care. All bills are subject to review, thus initial charges may not reflect my final bill.

Any patient portion must be paid in full at the time of service.

- We accept cash, check, Visa, MasterCard, Discover and American Express.
- We offer financing through CareCredit.
- There will be a $30.00 charge for returned checks.

Payment Agreement

I accept full financial responsibility for the treatment performed by this office. Insurance forms will be completed as a convenience to the patients, however, payment to Miller Family Dental is expected at the time services are rendered. Should the services of an attorney be required for collection of this account, I agree to pay all attorney's fees, court costs, and other costs of collection.

In regard to treatment of minors, a parent/legal guardian who accompanies a minor and gives permission for treatment is responsible for payment. Parents are jointly responsible for a minor's dental charges.

Regarding Insurance

Most insurance companies set reimbursements that are at or below our fees after co-payments, however, you are still responsible for the full amount of the bill. Insurance is a contract between you and your insurance company. We will not become involved in disputes regarding deductibles, co-payments, charges, "usual & customary" charges, etc. other than to supply factual information if necessary.

I understand the treatment planned for me and authorize the release of any information related to my insurance claim. I also authorize group insurance benefits to me to be paid directly to Miller Family Dental.

Insurance usually does not pay 100%, so we can only provide **estimates.** You are responsible for the **full amount** of treatment rendered, regardless of benefits covered by your dental plan. As a courtesy, we bill your dental plan provider on your behalf.

Late Accounts
Balances due for 60 days will be considered delinquent. We reserve the right to forward accounts which are delinquent to an independent service for collection. I agree to pay reasonable collection fees, attorney fees, and court costs incurred in the collection of my overdue account.

Cancellation Policy
When you schedule an appointment with us, that time is set aside specifically for you. As a courtesy to the providers, I acknowledge I may be subject to a **$50 charge** for a missed, cancelled, or rescheduled appointment when providing less than a 48 HOUR BUSINESS DAY notice.
Arriving late to an appointment may be treated as a cancellation. Your scheduled appointment duration is specific for your planned and agreed upon treatment. Arriving late can delay this treatment and may result in a charge.

_____
Print Name

_____ _____
Signature Date

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