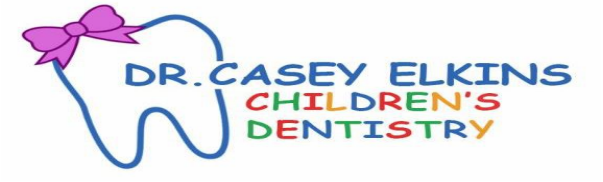

Financial Policy

As we enter this doctor-patient relationship, we agree to provide quality healthcare at a fair and reasonable price. You in return, agree it is your obligation to be prepared to pay at the time of service and to understand the benefits of your insurance. We want to explain our financial policy to you so that there are no unpleasant surprises.

- **Co-payments, deductibles and/or coinsurance are due at the time of service.** We accept Cash, Personal Check, Visa, MasterCard, Discover, American Express, Care Credit . If you are not prepared to pay the required amount, we are required to reschedule the appointment. The estimated financial responsibility for scheduled services will be due at the time services are provided unless earlier arrangements have been made. Any remaining balance after your health plan pays will be due upon receipt of statement. **If the insurance cannot be verified prior to the appointment, the account will be notated as private pay and payment will be due in full**. *Account balances over 90 days with no payment activity may be reported to the credit bureau.* **Initials** _____

- Your insurance policy is a contract between you and your insurer. **Do not assume your policy covers everything or pays 100%. It is your responsibility to know what your policy covers and what it does not.** We cannot guarantee your benefits our **treatment plans are estimations not guaranteed insurance payment amounts.** Any item deemed "non-covered" by your insurance carrier will be your financial responsibility. Any disputes about payment must be resolved between you and your insurance company. Failure to provide accurate insurance information within **3 days from the date of service** will result in the balance becoming your financial responsibility. **Initials** _____

- **As a courtesy to you we will file primary and secondary participating insurance for you.** I understand that all remaining balances are my responsibility to satisfy prior to additional services being rendered. If any **insurance changes please notify our office within 72 hours prior to an appointment**, failure to do so may result in you paying out of pocket for your child(ren's) appointments; as **we will not verify insurance changes same day of appointment**. **School holiday **Treatment & General Anesthesia appointments must be paid prior to appointment date. Initials:**_____

- A $35 fee will be assessed for all returned checks. A **$50.00 fee** will be added to your account each time a cancellation is made **without providing 24 hours' notice/no show** for regular appointments, any **treatment appointment canceled without 24 hours' notice/no show** will be charged a **$75.00 fee**. **A 5 minute** courtesy for appointment arrival will be given. We do understand that emergencies do happen as we will take that in to consideration if the need arises. **Please arrive 10 minutes prior to any appointment with our office. Initial:**_____

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.**If you miss an initial your signature will still be acknowledgment for full financial policy statement.

_____ _____ _____

Responsible Party Printed Name Responsible Party Signature Date