ELITE DENTAL CARE

FINANCIAL POLICY

OUR FINANCIAL POLICY
Please read and sign the following:

Payment is due at time of service. We offer several options of payment for the services we provide. We accept cash, checks, Visa, MasterCard, Discover, American Express and Care Credit.

FINANCIAL ARRANGEMENT MUST BE MADE PRIOR TO TREATMENT
We are committed to providing excellent dental treatment to all our patients. Our fees reflects our commitment to the quality our patients deserve and are considered usual and customary for the area regardless of any insurance company's determination.

INSURANCE
As a service to our patients, we will bill our insurance company. Your insurance policy is a contract between yourself and your insurance. As a health care provider, we are not a part in your agreement with your insurance company. Insurance companies vary and services provided may not be covered. The balance is your responsibility whether your insurance pays or not. If your insurance company sends a check to yourself instead of our office and if that money is for services rendered and payable to the office, it is your responsibility to make that exact payment to our office. Our office is committed to helping our patients maximize your benefits.

MISSED APPOINMTMENTS
One of the ways we keep our fees more affordable is by avoiding broken appointments. We understand that occasionally our patients will need to reschedule their appointments due to an emergency or illness. Please notify us 24-48 hours prior to an appointment to avoid a charge. The broken appointment fee of $50 will apply if it is within 24 hours with a general appointment and 48 hours with a specialty appointment.

SERVICE CHARGE
We will charge 450 for returned checks. If you have a payment and/or balance that is due and if it is not paid within 30 days of notice there will be a$50 late fee added to the balance. Fees incurred to collect payments will be billed to and payable by the patient and or Responsible Party.

BY SIGNING BELOW, I UNDERSTAND AND AGREE TO THE FINANCIAL POLICY AGREEMENT.

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Signature of Patient or Guardian Date