FINANCIAL POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care to educate your family, and to create caring relationships in a compassionate, child friendly atmosphere. It is our policy to make definite financial arrangements with you before any treatment starts. Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask.

1. Payment for services is due at the **time services are rendered.** We accept **cash, checks and credit cards:** Visa, Mastercard, Discover and Carecredit.

2. We accept most insurance, however, **we are not in-network with any insurance plan.** Our fee schedule is the same for all patients, with or without insurance.

3. **As a courtesy**, we will provide you with a copy of the charges to submit to your insurance carrier for your reimbursement or you may assign the payment to our office and **we will file the insurance for you**.

4. You must provide the office with a **dental (not medical)** insurance card with the proper mailing address of the insurance company, or provide a **dental (not medical)** claim form which is provided by the employer. If one of these documents is not available at the time of the appointment, you will be responsible for payment of all fees and we will provide you with a claim form for you to submit for reimbursement.

5. If insurance benefits are assigned to the doctor, you will be responsible for **paying your deductible and co-payments at the time of service. You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule.**

6. Your insurance benefits are a contract between you and your employer. The amount of coverage you will receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor.

7. **The office can not carry balances longer than 90 days; regardless of insurance payment.** After 90 days, we will inform you of the delinquent account by letter and if no action is taken to clear the account, this office will be required to employ a **collection service** to collect payment. **A $25.00 collection fee will be added to the account.**

8. There will be a **$25.00 service charge** for all returned checks

9. The **parent or guardian who brings the child for their initial visit is responsible for payment** independent of what a divorce decree may state. Reimbursement must be made between the divorced parents. **We will not intervene.**

AUTHORIZATION

1. I authorize Dr. Tammy Gough, Dr. Jessie Hunter, and staff to release any information concerning my case to my insurance company.

2. I have read and accept the above Financial Policy, understand it and agree to the terms set forth regarding payment.

______________________________ ______________

Signature of Parent or Responsible Party Date