Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement from our Financial Policy, which we require that you read, agree to, and sign.

FULL PAYMENT is due at the time of service is provided. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made. For your convenience we accept all methods of payment (cash, personal checks, MasterCard, Visa, Discover, Apple Pay, Samsung Pay, American Express and CareCredit). When more extensive dental care is necessary, financial arrangements can be made with our office prior to treatment. Please note: Additional fees will be applied for returned checks. Unpaid balances over 60 days old will be subject to monthly interest of 1.5% (APR 18%). If payment is delinquent, the patient agrees and will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account. When all efforts have been made for account balances not paid and over 90 days delinquent, your account will be turned over to collections.

Do you have dental insurance?

- As a courtesy to you, we will help you process and submit your claim(s) to your dental insurance. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles, and maximums, which are solely your responsibility. Please contact your insurance company for details of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to several reasons, specifically related to your plan.

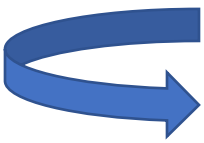
- All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.

- Our practice is committed to providing the utmost care and best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

- We ask that you sign this form and/or any other necessary documents. This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

- We ask that you pay the deductible, co-payment, and co-insurance, which is the estimated amount not covered by your insurance company - by cash, check, MasterCard, Visa, Discover, Apple Pay, Samsung Pay, American Express or CareCredit at the time we provide the service(s) to you.

OVER TO REVIEW & SIGN



• Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

• We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter a dispute with your insurance company over any claim.

No dental insurance?

If you do NOT have dental benefits, we offer an in-house Dental Discount Plan. An Individual plan is $340 per year. This includes 2 regular cleanings, 2 Exams, and any necessary xrays in the contracted year, as well as 25% off any necessary dental treatment. Perio cleanings are not included as regular cleanings and are comped at 25% off. When using this plan, it cannot be combined with any other offer or insurances.

Missed Appointment(s) and Cancellations:

Our goal is to provide treatment in a timely manner with as few visits as necessary. To provide the best services and care for our patients, we require a 24-hour notice for cancellations or for rescheduling your appointment. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

Consent:

I have read, understand, and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment is responsible for full payment at time of service. Unaccompanied Minors: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or nonemergency treatment may be denied.

Communications with you:

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. We may call by telephone regarding your account. You agree that we may place such calls using an automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device.

X _____ _____

Patient /Parent name printed Patient /Parent signature Date

OVER TO REVIEW & SIGN