DENTAL COMFORT ZONE

TREATMENT POLICIES

FEES: We are happy to provide you with a fee estimate for all the treatment that is needed. Payment for these services will be requested at the time the service is rendered. For lengthy, multiple visit treatments, payment in full is due prior to the final visit for that treatment.

INSURANCE: For your convenience, we will submit all insurance forms accepted by the office either manually or electronically through the computer. You are responsible for payment of all differences and unpaid insurance claims for treatment completed. For more extensive treatment, we will gladly submit a pretreatment estimate of expected coverage prior to your appointment.

BILLING: In order to keep billing and mailing costs down, we request payment at the time the service is rendered. This practice will minimize any future fee increases, and help keep the standard of care high. All treatment over $500 that is paid in advance will qualify for a 5% discount.

MISSED APPOINTMENTS: There will be no charge for a missed appointment provided at least 12 hours notice is given. Our time is very valuable to us, as yours is to you, so please inform us if you can not come in at the scheduled time. There are many patients who are awaiting treatment. Any patient who does not inform the office of a cancellation more than one time will forfeit the right to reserve valuable appointment time in advance.

FINANCING: Financing is made available through Norwest(0% interest available), electronic funds transfer (0% interest), or a major credit card. Details of payment plans will be explained at the front desk.

METHODS OF PAYMENT: Fees may be paid by insurance, cash, personal or business checks, Visa, Master Card, American Express, Discover, MAC card, electronic funds transfer or Norwest.

Please be advised that all unpaid debts will be subject to a 1% monthly (12% per annum) finance charge 60 days after your bill is received. A minimum charge of $5 will be charged after 60 days to cover billing costs. Any reasonable collection or legal fees associated with collection of any unpaid debts will be the responsibility of the patient.

The patient (guardian) agrees to be fully responsible for total payment of procedures performed in this office, including any treatment not a benefit of any insurance the patient may have. I certify that I have read, understood, and agreed to this, and have had the opportunity to ask questions regarding the above.

PATIENT'S
SIGNATURE____________________________________ DATE____________________
(PARENT/GUARDIAN IF PATIENT IS A MINOR)

WITNESS____ DATE____________________
(DOCTOR'S REPRESENTATIVE)