McCormack DENTAL

FINANCIAL POLICY

First, we at McCormack Dental group would like to thank you for choosing us to be your dental health care provider. We are committed to providing you and your family the best treatment possible. In order for us to achieve these goals, we need your assistance and your understanding of our financial policy. Please read the following:

Insurance and Payments: We are happy to file insurance claims for any services covered by your dental plan. We are committed to helping patients maximize their dental benefits. Please remember that most insurance companies do not pay all dental costs and treatment is recommended based on what is needed, not what your insurance covers. Therefore, it is your responsibility to pay any deductible, estimated co-payment, or other balance not paid by your insurance. As a courtesy, our knowledgeable staff will provide you with a written estimate of treatment and anticipated benefits from your dental carrier. However, we cannot guarantee that your dental insurance will cover exactly as estimated. We will always do all we can to ensure your estimate is as accurate as possible. Your estimated copay is due at the time of treatment.

Payment may be made by cash, check, and we accept most major credit cards
3rd Party financing is available through Care Credit
Please speak with our front office coordinators about payment plans offered through Care Credit prior to reserving your appointment.

Returned Checks: A returned check will be assessed a $35 fee. Additionally, check payment will not be an option for future payments.

Delinquent Accounts: If an account should become delinquent and the services of a collection agency are utilized the patient balance will incur an additional fee of the total account balance reported to the collection agency. Ultimately, the patient will be responsible for the total collection amount, collection agencies fees associated with the recovery of the monies due on the account.

Missed Appointments, Cancellations and our No Show Policy: Appointments are reserved exclusively for you at the time of scheduling. We respectfully request you notify the office of any need to reschedule an appointment at least 24 hours in advance. Repeated offenses of our cancellation policy may result in the inability to pre-schedule your appointments or dismissal from the practice.

Thank you again for giving us the opportunity to serve your dental needs. If you have any questions about this form or any of our services, please let us know. Signing below indicates you have read and understand our financial policy for payment of dental services and our no show policies.

Signature: _____ Date: _____

Patient of Responsible Party (Please Print): _____