Dental Financial Policy and Agreement
Dr. Barbara E. Baxter D.M.D

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care.

Payment

We offer several payment options:

_ Cash, Checks, Visa, MasterCard, Discover and American Express

_ Pre-payment discounts

_ Monthly payment options – If you need to make long-term payments we can offer financing with CareCredit which offers up to 12 months NO INTEREST financing as well as longer terms with low interest rates. You must qualify for this option. Please do not hesitate to ask us about this option. We may conveniently quality you right here in the office today.

Insurance

Our office is committed to helping patients maximize their benefits. Because insurance policies vary greatly, this is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. All charges you incur for any treatment that is provided are your responsibility regardless of your insurance coverage. We will always **recommend** treatment based upon your dental needs, not based on insurance coverage, which can be inadequate with some dental plans. Dental insurance is a benefit used to assist you, not to dictate necessary treatment. We can estimate your coverage, but cannot guarantee it. As a service to our patients, we will be happy to manage all claim submission and follow up on your behalf. If your claim is denied or the treatment is down-coded and or alternative benefits given, you will be responsible for paying the full balance amount left on the account at that time. _____ **(please initial)**

If your insurance company has not made payment within 30 days of billing, the balance will become your responsibility. Insurance coverage is a contractual agreement between the insurance company and you or your employer.

Missed Appointments

Once an appointment has been made, that time is reserved specifically for you. We reserve the right to charge a fee for all canceled or missed appointments without 48-hours notice.

Collection Fees

Fees incurred to collect payment will be billed to and payable by the patient's account holder.

Financial Consent

The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.

I understand and agree to this Financial Policy and Agreement

_____ Date _____

Signature of patient/responsible party Date

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