OUR OFFICE AND FINANCIAL POLICY

Dr. Melvin Boule'

Thank you for choosing us for your dental needs. We are committed to proving you with excellent care and convenient financial arrangements in order to insure the best possible experience. Please read the following, sign and return.

PAYMENT

Payment in full for services planned for that treatment day is expected at the time of service unless prior arrangements have been made with our financial coordinator. We accept personal checks, Visa, MasterCard and Discover credit cards. We also accept Care Credit.

INSURANCE

Our office is committed to helping our patients maximize their insurance benefits. As you may be aware dental insurance is extremely complex. We are always available to answer your questions, however, your insurance policy is an agreement between you and your employer/insurance carrier and as a dental provider, we are not party to that agreement. Your *patient portion must be paid before or at the time of services*. We ask our patients to provide us with their complete insurance information. *If the information provided is incorrect, you will be responsible for payment in full immediately and submission of claims for any treatment rendered.* As a service to our patients, we will process all primary and secondary insurance claims for services and allow them 45 days to render payment in full. After 60 days, the patient is responsible for the entire balance and it will be due in full. The qualities of insurance policies vary greatly; therefore we can estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts.

MINORS

Payment for services for the treatment of minors is the responsibility of the adult accompanying that minor.

MISSED APPOINTMENTS

Once an appointment has been made, please remember that this time has been specifically reserved for you. We will make every effort to remind you of your appointment but, ultimately, your appointment is your responsibility. *We reserve the right to charge a fee for any appointments that are missed or cancelled within a 24 hour period of the appointment.*

SERVICE CHARGE

Any fees incurred to collect payment from a professional agency will be billed to and payable to the patient or the patient's responsible party. We will charge a $50.00 fee for all returned checks.

FINANCIAL CONSENT

The patient or responsible party agrees to be fully responsible for the treatment performed in this office.

I understand and agree to the Office and Financial Policy and Agreement.

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Signature of the Patient /Responsible Party Date