

Valerie M. Preston, D.D.S.
8320 Falls of Neuse Rd
Raleigh, NC 27615

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our information and insurance form before seeing the doctor.

REGARDING PAYMENT:

We accept the following forms of payment: Cash, Check, Visa, MasterCard, American Express, Discover, & Care Credit.

Payment of services is due at the time services are rendered unless prior financial arrangements have been made with the Office Manager.

If dentures, partials or crown and bridge are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is delivered.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the Office Manager.

Checks that are returned to our office from your financial institution are subject to a \$35.00 returned check fee. This fee covers the processing fees that are charged to our office.

Appointments scheduled 2 hours or more will automatically require a 25% deposit to hold your appointment time due at the time of scheduling. You will lose this deposit if you cancel outside of our office policy or if you do not show up for your appointment. (i.e. Last minute business or no childcare **NOT** considered an emergency.)

REGARDING INSURANCE FOR NEW PATIENTS:

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. You are required to pay for services rendered in full the day of your appointment if your insurance does not accept assignment of benefits to dentist who are out of network. Your complete insurance information must be presented at the time services are provided; if this is done we will be happy to file your insurance with the insurance company reimbursement going directly to you.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Please let us know if you have any questions or concerns. Please acknowledge that you have read the Financial Policy.

I understand and agree to this financial policy.

Signature of Patient or Responsible Party: _____ Date _____