PATRIOTS PARK DENTAL
General • Restorative • Cosmetic

Our Office Financial Policy

Thank you for choosing us as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment. All patients must complete our information and insurance forms before being seen by a provider.

FULL PAYMENT IS DUE AT TIME OF SERVICE. The parent/guardian of any minor patient will be responsible for payment. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AND DEBIT CARDS.
We do not accept AMERICAN EXPRESS or CARECREDIT.

Regarding Insurance
We request that any co-payments, deductibles, and any services not covered by your insurance plan be paid at the time the service is provided. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you provide all insurance information for each visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. Please be aware some and possibly all the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of your dental policy.

Missed Appointments
Unless cancelled at least 24 hours in advance, our policy is to charge $50 for missed appointments. Please understand that missed appointment times are valuable to those patients that may find it hard to come to the dentist at other times. Please help us serve you better by keeping your scheduled appointments. Excessive cancellations and no shows will result in termination of our treatment agreement and your records can be forwarded to another dental office.
Failure to confirm your appointment will result in cancellation and will require you to reschedule.

Billing
Balances which are 60 days old or older will incur a monthly 1.5% finance charge which equals an 18% yearly rate. There is a $30 returned check fee.

Refunds
Refunds for overpayment will be sent after all treatment is completed and insurance has been collected.

Collections
Any account that has not received payment in 60 days will be handed over to a collection agency that will pursue the responsible party for reimbursement. This will negatively impact your credit history and limit the treatment you can receive at our office.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere.

INITIAL_____I have thoroughly read the Financial Policy and understand and agree to this Financial Policy.

Patient's Name (Please Print) _____

Patient/Parent or Guardian Signature _____ Date _____

Patient/Parent or Guardian Social Security # _____-_____-_____

Form Updated 3/2/23