Patient Name: _____

Date of Birth: _____

Patient Financial Policy

We are committed to providing you with excellent dental care and transparent financial expectations. Please take a moment to review our office financial policies below.

Payment Methods

We accept the following forms of payment:

- **Cash**
- **Zelle**
- **Major Credit Cards** (Visa, MasterCard, American Express, Discover)
- **Select Payment Services**: We partner with third-party financing services (e.g., [CareCredit, Sunbit, etc.]) for patients who qualify. Please ask our front desk team for details or assistance with the application process.

All payments are due at the time services are rendered.

Dental Insurance

As a courtesy, we will submit claims to your dental insurance provider. However:

- You are **responsible for understanding your insurance coverage**, including deductibles, co-pays, and benefits.
- Any **estimated patient portion** is due at the time of service.
- Final financial responsibility rests with the parent/guarantor for all charges not covered by insurance, including any denied claims.

We recommend contacting your insurance provider prior to your visit to verify coverage and benefits.

Pre-Treatment Estimates

Upon request, we can provide a written estimate of charges based on your proposed treatment plan. Please note this is only an estimate and may change based on clinical findings and your insurance provider's payment.

Missed Appointments / Cancellations

To help us provide efficient care for all patients, we require at least **24 hours' notice** for cancellations. A **missed appointment fee** of $250 may be charged for no-shows or late cancellations.

Returned Payments

Declined electronic payments will be subject to a **$25.00 service fee**.

Outstanding Balances

Balances unpaid after 30 days may be subject to collection activity and/or finance charges. Please communicate with our office if you require a payment arrangement or are experiencing financial hardship.
If you fail to make timely payments, you will be responsible for all costs of collection monies owed, including court costs, collection agency fees, and attorney fees.

Acknowledgment

By signing below, you acknowledge that you have read and understood this Financial Policy and agree to comply with its terms.

Parent/Guardian Name: _____ Relationship to patient: _____

Signature: _____ Date: _____