

## FINANCIAL POLICIES

*Forms of Payment Accepted: Cash, Credit cards: Visa, Master Card, American Express, Debit Cards*

1. All fees are due the day services are rendered.
2. Payment in full at the time treatment begins: **5% discount given.** (Only on large non insurance cases.)
3. Payment in full 2 days prior to treatment: **10% discount given.** (If an appointment is cancelled the 10% discount is forfeited and payment in full is required before treatment begins.) (Only on large non insurance cases.)
4. Care Credit is a credit card you apply for at our office. Depending on the amount applied for, you may be eligible for a 6 or 12 month interest free period, if approved.
5. If you do not have any form of approved credit: **All fees are to be paid in full the day treatment is started and before treatment begins.**
6. **NO SHOW OR CANCELLATION OF AN APPOINTMENT POLICY**  
We charge a \$25 fee for missing an appointment without calling **at least 24 hours** in advance, or not showing up at all. The \$25 fee will be charged to your account the day the appointment is missed.
7. **REGARDING INSURANCE**  
We will accept assignment of insurance benefits. However, we do require your deductible (when it has not been met for the year yet) and the co-payment (usually 20%-50%) to be paid at the time of service. **Please also note that we expect you to know your insurance plan limitations, (what is and isn't covered, your percentage and yearly maximum, we do not call your insurance company), this is your responsibility.** The balance is your responsibility whether your insurance pays or not. 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 60 days, the balance will automatically due and payable by you.
8. Weekend or Holiday visits will be charged \$75.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to the financial policy.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date