BRUCE
FAMILY DENTAL

FINANCIAL POLICY AND AGREEMENT

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care and convenient financial arrangements. We feel that an important aspect of your dental treatment is for you to understand our financial/claims processing policies.

Payment

Payment in full is due at time of service. All insurance co-pays and deductibles must be paid at the time of service. The parent that accompanies minor children will be responsible for any payment due the day of service. Checks that are returned to our office from your financial institution will be subject to a $30.00 return check fee. For your convenience, we offer several payment options.

1) Cash, check, Visa, MasterCard, Discover & American Express.
2) Prepayment discounts if paid with cash or check.
3) CARECREDIT is available with an approved application providing patients the flexibility of a monthly, no finance charge, interest free payment.

Insurance

Your complete insurance information must be presented at the time services are provided. All benefits must be verified before your insurance company can be billed. Every attempt will be made to determine an estimate of the insured's coverage, but because the insurance policy is an agreement between your employer and the insurance company, we can make no guarantees. If payment is not received from your insurance carrier within 45 days of filing the claim, the balance will be due. We cannot become involved in disputes between you and your insurance company regarding coverage.

The office of Bruce Family Dental will not submit claims to Medicaid or Medicare. We do not participate with any type of discount or reimbursement plans.

Specialty Services

A 50% deposit is due at the time of appointment scheduling for all surgical procedures and major restorative procedures.

Appointment Policy

We require a 24 hour advance notice for appointment cancellations. A fee will be charged for appointments cancelled with less than a 24 hour notice.

I have read the financial agreement. I understand and agree to this financial policy.

Signature of Patient or Responsible Party_____ Date_____