LUSK FAMILY DENTISTRY

Financial Policy

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. All charges you incur for any treatment that is provided are your responsibility regardless of your insurance coverage. We will always recommend treatment based upon your dental needs, not based on insurance coverage, which can be inadequate with some dental plans. Dental insurance is a benefit used to assist you, not to dictate necessary treatment.

Payment is due at time of service. We accept Cash, Check, Visa, Mastercard, Care Credit, and Discover. Debit cards displaying the Visa, Mastercard logo are also accepted. You may also use your flexible spending account through your employer.

How would you like to pay for your services? Please check one:

_____Cash _____Check _____Credit/debit card

If you have dental insurance, we will be happy to file your dental insurance claim as a courtesy to you. However, your estimated portion is just that, an ESTIMATE. If there is any remaining balance after we receive payment from your insurance company, that balance will be due immediately. Any unpaid balance after 30 days will be subject to an interest charge of 1.8% monthly (21.6% annually). Failure to pay your account balance will result in your account being turned over to a collection agency. At such time, additional processing fees will be added and this action will adversely affect your credit rating.

Appointment Policy

We value your time and always try to serve you in a timely manner. We request that you extend the same courtesy to us. Should you need to change a scheduled appointment, we **require** being informed at least 24 hours in advance. ***Due to the large amount of time involved in treatment, other patients who may wish to take advantage of your appointment time require at least 24 hour notice to accommodate their schedule. Failure to notify our office within 24 hours may result in a fee of $50.00 to your account.*** This fee must be paid before any subsequent appointments will be scheduled. Emergencies will be taken into consideration.**If you are over 15 minutes late for your scheduled appointment it may be necessary to change your appointment. We reserve the right to stop seeing patients who are habitually late or miss appointments.

I understand the financial policy and appointment policy as stated. I understand that I am responsible for my dental cost regardless of any insurance coverage. I agree notify the office within 24 hours to change a scheduled appointment.

Signature _____ Date_____