iSmile Dental Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we required that you read and agree to sign prior to any treatment. All patients must complete our "Patient Information Form" before seeing the doctor. Full payment is due at time of service. We accept cash, Visa, MasterCard, American Express. We also offer Care Credit, which is an extended payment plan with prior credit approval.

Regarding Insurance

We accept assignment of insurance benefits; however, 20-50% of the fee is to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information. Your insurance policy is a contract between you and your insurance company. We are not a part of that contract. If your insurance company has not paid your account in full within 45 days, the balance of your account will be due. Please be aware that some of the services provided may be "non-covered" services under your insurance, and therefore, your full financial responsibility. Regardless of the insurance company's determination of usual and customary rates or amount of assignment, you are required to pay the full amount charged.

Minors

The adult accompanying a minor and the parent or guardian are responsible for full payment. For unaccompanied minors, non-emergency treatment will not be rendered unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, American Express or payment by cash at time of service.

Missed Appointments

Productive appointment scheduling requires that you honor the appointment time that has been set aside for you. If there is a need to reschedule an appointment, we ask that you give us a minimum of 48 hours notice, so that we may offer the time to another patient. We realize that there are certain emergencies that may occur, so it is our office policy that after the first broken appointment (an appointment cancelled with less than 48 hours notice), or the first "no-show" for a scheduled appointment, a $50.00 per-hour charge will be added to your account for any subsequent appointments that are broken. We thank you for your cooperation.

I have read, understand, and agree to the above Financial Policy

_____

Patient or Responsible Party Date: _____