

GENTLE FAMILY DENTISTRY & ORTHODONTICS

Sage L. White, D.D.S., F.A.G.D., P.C.

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- All patients must complete our "Patient Information Form" before seeing the doctor.
- FULL PAYMENT IS DUE AT TIME OF SERVICE.
- We accept cash, checks and Visa/MasterCard.
- Financing is available through Orthodontists Fee Plan for both orthodontics and/or dentistry.
- Financing is available through participating banks for dentistry.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor is responsible for full payment at the time of service, unless prior arrangements have been made.

UNACCOMPANIED MINORS

The parents (or guardians) are responsible for full payment. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan or to Visa/MasterCard, or paid by cash or check at any time of service.

REGARDING INSURANCE

If you have insurance, we would like to help you receive maximum benefits. On your first visit, we **MAY** accept your insurance if you obtain approval from our office staff prior to the date of service. If we accept your insurance, you must pay at least **20%** of the total charges at the time of service; some procedures may require a **50%** payment. If your insurance company has not paid within 45 days, you have 15 days to pay the balance. Late Payment Charges are added to unpaid accounts after 60 days from the date of service. If your insurance company pays more than the balance due, we will either credit your account or send a refund check to you.

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party to this contract. (We will inform you if we are a party to your insurance.) We file insurance claims AS A COURTESY to our patients. We will NOT become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc., other than to supply factual information as necessary. YOU are responsible for the timely payment of your account.

MISSED APPOINTMENTS

Unless canceled at least **24 HOURS IN ADVANCE**, our policy is to charge for missed appointments at the rate of \$25 per half-hour that was reserved for you. Please help us serve you better by keeping scheduled appointments. _____ (*Please Initial*)

It is understood and agreed that if you fail to pay for your account in accordance with these terms and conditions, and it becomes necessary to place your account with a collection agency, you will be liable for costs incurred for such service. This includes 45% collection charges, as well as reasonable attorney fees and court costs, if applicable.

I acknowledge that I have read the Financial Policy and do hereby agree to the terms herewith.

Patient Signature Or parent if minor _____	Date _____
Patient Name (Please Print) _____	Date _____