# Financial Policy

1. Charges for services rendered are due and payable the day of the appointment.
2. We accept payments in the following forms:
    A. Cash
    B. Visa, MasterCard, and Discover
    C. Personal Checks
    D. Financing options: Care Credit
3. It is your responsibility to provide us with **correct information** relative to your claim; including insurance card, ID number, employer, birth date, address, Social Security number and to notify us of any changes immediately.
4. **We will assist with filing insurance; however, the Patient, Parent, or Guardian is directly responsible for payment in full of any and all fees not paid for by the insurance company.** There are no exceptions. When treatment co-pays are quoted by the office, these are estimates only, your actual insurance coverage may be less or more.
5. Personal checks that are returned due to "insufficient funds" are subject to a $25.00 service fee.
6. **Appointment cancellations with less than 48 hour notice are subject to a fee of $50.00 for cleaning appointments and 50% of scheduled production for longer appointments.** After 3 broken appointments we reserve the right to terminate our patient/doctor relationship.
7. All accounts over 60 days will be considered past due and are subject to a $25.00 billing charge. Past due accounts maybe referred to an authorized collection agency. Accounts sent to a collection agency will be assessed a $15 collection fee or 33.3% collection charge on the unpaid balance, whichever is greater. The patient, Parent, or Guardian will also be liable for any applicable attorney fees and court costs.
8. Amalgams (silver fillings) are no longer used at this office. Most Insurance companies do not pay full benefits due to exclusions in individual policies for composite (tooth colored) fillings. The patient, parent or guardian is liable for all additional costs.

I have read and understand the Financial Policy of CNS Dental. I agree to be responsible for all dental services and materials not paid by my dental insurance for me and/or my dependents. I authorize release of any information relating to any insurance claims to the relevant insurance company. I authorize payment of dental insurance benefits to CNS Dental, unless payable to me directly per the insurance plan.

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Signature of Patient/Parent/Guardian of minor Date

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Print Name