York Family Dental
We'll make you smile!

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. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities.

To confirm your understanding and agreement with our policies, please read the following:

Payment

Payment in full is due at time of service unless prior financial arrangements are made. Our practice accepts cash, checks, Visa, MasterCard and Discover cards.

We find that some of our patients prefer to divide the cost of treatment up into equal monthly payments using an outside financing arrangement. Ask us about Care Credit ™ if this would help to make the investment in your dental health more comfortable for you.

Insurance

Insurance is a contract between the patient and/or employer and the insurance company. It is not a contract between our office and your insurance company. Our office is committed to helping patients maximize their benefits. Insurance policies vary greatly. Therefore, owing to the complexity of insurance contracts, we can only estimate in good faith, not guarantee coverage. Your estimated patient portion must be paid at the time service is delivered. As a service to our patients, we will bill your insurance company for service and allow 45 days for them to render payment. After 60 days, you are responsible for the entire balance and it will be due in full. **First office visits that are Emergency Visits, full payment will be expected regardless of insurance.**

Minors

Payment for services for the treatment of minors and is the responsibility of the adult accompanying the minor.

Missed Appointments

Once an appointment has been made, please remember that this time has been reserved specifically for you. We reserve the right to charge a $75.00 fee for each hour scheduled for all cancelled or missed appointments without 48 hours notice.

Service Charges

The policy of this office is to charge 1.5% monthly interest (18% annual percentage rate). We will charge $40 for returned checks.

Collection Fees

In addition to the outstanding account balance, all fees incurred to collect payment (including collection agency and legal fees) will be billed to and payable by the patient's account holder.

Financial Consent

The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.

I understand and agree to this Financial Policy and Agreement.

X_____

Patient or Responsible Party Date