

FINANCIAL & APPOINTMENT GUIDELINES

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 guidelines, which we require you read and sign prior to any treatment.

- FULL PAYMENT IS DUE AT TIME OF SERVICE
- WE ACCEPT CASH, CHECKS, VISA, MC, AND DISCOVER
- WE OFFER EXTENDED PAYMENT PLANS WITH PRIOR CREDIT APPROVAL THROUGH CARE CREDIT

To our patients with dental insurance, you are most fortunate, please read the following regarding insurance reimbursement:

We are happy to cooperate with families who are covered by dental insurance. We ask only that you read YOUR policy to be sure that you are fully aware of any limitations of benefits provided.

DENTAL INSURANCE IS DESIGNED TO REDUCE THE COST OF CARE, BUT NOT ELIMINATE IT ENTIRELY.

We will gladly file your insurance claims for you and we accept direct payment from most insurance companies. We ask that you remember – we have no control over what will be covered nor the length of time the insurance company takes to process the claim. If your insurance company has not paid your account in full within 45 days, payment in full of the balance will be your responsibility. Since your dental insurance is a contract between you and your insurance company, the ultimate responsibility rests with you for any dental charges incurred. Your co-payment and deductible are due at the time of service. Please feel free to discuss your coverage with us if you have any questions.

Adult Patients

Adult patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor and parents are responsible for full payment. For unaccompanied minors, non-emergency treatment charges must be pre-authorized to an approved credit plan, major credit card, or payment by cash or check at the time of treatment.

Missed Appointments

We respect your time and ask that you respect our time as well. When we schedule an appointment for your treatment, we are reserving that time specifically for you. Please have the courtesy to inform us in advance if you are unable to keep your appointment. Unless cancelled at least 24 hours in advance, our policy is to charge a fee of \$35 for missed appointments. Please help us serve you better by keeping scheduled appointments and arriving on time.

Thank you for understanding our financial and appointment guidelines. Please let us know if you have any questions or concerns.

I understand that where appropriate, credit reports may be obtained. I have read and agree to Dr. Thomas J. Giroux's Financial Guidelines.

X _____

(Signature of Patient or Responsible Party)

(Date)