# FINANCIAL POLICY

Thank you for choosing *Comfort Dental Care* as your dental provider. We are committed to your treatment being successful. Fees are based on treatment received and have no bearing on outcome. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.
FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, OR DISCOVER/VISA/MASTERCARD.

*Regarding Insurance*
We will submit all treatment charges to your insurance company as a courtesy to you, if you provide us with the correct address and phone number of your insurance company. The balance is your responsibility whether your insurance company pays or not. You are responsible for paying the co-payment and any deductible at the time of service. If your insurance company has not paid your account in full within 45 days, you must pay the balance in full.

*Usual and Customary Rates*
Our practice is committed to providing the best treatment for our patients and our fees reflect the quality of service and the care with which it was delivered. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

*Missed Appointments*
Unless cancelled (at least 2 working days notice) we reserve the right to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments. A refundable deposit will be required to reserve time for appointments one hour or longer. The deposit will be refunded when the patient comes in for the scheduled appointment or gives required notice before cancelling appointment.

All patients assume full responsibility for any costs incurred for treatment rendered along with any court costs, collection fees, and attorney fees incurred in collecting said account. Please note that all accounts 60 days or older will accrue 18% annual interest charge.
Thank you for understanding our Financial Policy:

Signature_____ Date_____

Patient Name_____Relationship_____