FINANCIAL POLICY

Thank you for choosing Firlik Family Dentistry as your dental care provider. We are committed to quality patient care. This is our financial policy, which you should understand prior to treatment.

Please understand that payment for services is due in full at the time of treatment. We accept cash, checks, Visa, Master Card, American Express, Discover, Care Credit, and Lending Club. **There will be a fee for any returned check, equal to the fee assessed us by our bank.**

Regarding insurance:

As a courtesy to you, we will file claims with your insurance company. **However, your insurance policy is a contract between you and your insurance company. We have no control over its decisions and the amount it decides to pay.**

Before filing a claim on your behalf, we will attempt to verify your coverage and calculate your deductible and co-payments as accurately as possible. Please remember this is only an estimate. All deductibles and co-payments are due at the time of service.

Your insurance company will not guarantee payment over the telephone. We will not know the exact amount it pays until it responds to the claim that we file. **Regardless of what your insurance company decides to pay, you remain responsible for payment of your bill in full.** Once we receive payment on your claim, we will send you a bill for any balance remaining on your account. This balance is due in full upon receipt of statement.

Cancellation policy:

We understand that occasionally you face an emergency when you need to cancel or reschedule your appointment. Please remember that missed appointments can compromise your oral health and will result in the loss of valuable professional time for other patients. If you need to cancel or reschedule your appointment, please give us at least **48 HOURS NOTICE,** to avoid being charged a **BROKEN APPOINTMENT FEE OF $50.**

I have read and understand this financial policy. By signing below, I acknowledge responsibility and agree to the terms as written above.

Printed Name of Responsible Party: _____

Signature of Responsible Party: _____

Date: _____

Witness: _____