MERIDIANDENTAL

FINANCIAL POLICIES

In order to enhance communication and promote understanding regarding this office's financial policies, please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please ask to speak with the office manager. Thank you.

Insurance: We are happy to bill both primary and secondary insurances as a courtesy for our patients. It must be understood that each patient is ultimately responsible for the cost of services rendered. We will do our best to estimate accurate insurance coverage and patient portions due; however, if the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Payment would be expected within 30 days of receiving a statement.

Patient Payment: The patient portion due for services rendered is expected at the time of service unless *previous* arrangements have been made with the office manager. We accept cash, checks, and all major credit cards.

Financing: We have financing options available through Care Credit. If you have an interest in this option, please consult with the office manager prior to the date of scheduled treatment.

No Shows/Missed Appointments: We request notice to cancel or reschedule an appointment at least 48 hours in advance. If appropriate notice is not given, a charge of $50 may be assessed to the patient's account. After three missed appointments or same day cancellations a dismissal letter will be issued.

Refunds for Unfinished Treatment: If a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office manager and/or dentist.

Credits on an Account: If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied toward future treatment.

Patient Name: _____

Guarantor Name: _____
(Person financially responsible for account)
Guarantor Signature: _____ Date:_____