FINLEY
Periodontics
PLLC

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We welcome you to our office. We are committed to your treatment being successful. Please understand that payment of your bill is 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.

Payment is expected as services are rendered. If you are covered by dental insurance, we expect payment for deductibles and co-payments on the date of service. For your convenience we accept **Cash, Check**, **Visa**, **MasterCard**, **American Express, Discover** and **CareCredit**.

Regarding Insurance

We are happy to extend the courtesy of billing your insurance company for you. However, in order to provide this service to you, we must have **COMPLETE** insurance information and confirmation of your coverage. It is your responsibility to fill out the necessary forms that give us all the insurance information required. If this information is not provided to us in a timely manner, we will be unable to bill your insurance company for you and you will be expected to pay in full for services rendered. If we have not received payment from your insurance company within 45 days of billing, the balance is due and payable by you, the patient. Your insurance is a contract between you and your insurance company and we are not a party to that contract. You will be expected to contact them directly if a problem should arise. We expect all balances to be cleared in less than 60 days.

We do NOT accept or file with Medicare, Medicaid, and/or any medical insurances.

Usual and Customary Rates

Our practice is committed to providing the best treatment and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please keep in mind that we can only **ESTIMATE** what your insurance will pay since each insurance company has their specific limitation and exclusions.

Billing

For all accounts over 60 days with patient amounts due, there will be a finance charge of 1.5% per month.

All returned checks will be subject to a $25.00 returned check fee.

All accounts over 120 days will be assigned to a collection service for processing. Should this situation arise, you agree to pay any reasonable additional fees, including any and all collection agency, legal fees and/or court costs, necessary to collect this account.

Missed Appointments/Cancellation of Appointments

We understand that emergencies do arise. However, because we reserve specific times for you and your treatment, a 24 hour notice for non surgical appointments and a 48 hour notice for surgical appointments are required. Otherwise a charge of 50% of the scheduled appointment will be billed to your account. Rescheduling of a surgical appointment will require a 20% non-refundable deposit. While we try our best to confirm your appointments by phone, this is a courtesy and asks that you not rely on this. It is the patient's responsibility to know their appointment times.

I have read and agree to this financial policy:

_____ _____

Patient or Parent/Legal Guardian Signature Date