Divine DENTAL CENTER

FINANCIAL POLICY

- I understand that I am responsible for all fees related to my dental care and treatment.
- I understand that full payment for all dental treatment is to be paid at the time of service. For your convenience we accept Cash, CareCredit, Discover, MasterCard and Visa.
- **I understand that a deposit maybe required for scheduling subsequent appointments after the initial exam.**
- I understand that any and all account balances over 30 days old may incur a monthly interest charge at the maximum rate.
- I understand that if any electronic authorization or debit sent or provided to Divine Dental Center for payment is not honored upon first presentation, regardless of the reason, even if the electronic authorization was later honored. I may be charged a service fee.
- I understand that if my account is not paid on time, my account may be turned over to collection agency. In addition to paying my balance, I agree to pay all Attorneys' fees, collection and/or other court costs.

BROKEN AND/OR MISSED APPOINTMENTS

- Divine Dental Center requires a **forty eight (48) hours notice** for any appointment changes.
- Divine Dental Center reserves the right to charge a **$50 fee** for any appointment not kept by the patient. After one (1) broken or missed appointment, the dentist retains the right to provide only emergency care, discontinue elective treatment or dismiss the patient from the practice.
- Divine Dental Center reserves the right to only schedule one (1) or (2) patients per family after one (1) no show/missed/or cancelled appointment for a family of two (2) or more patients.

PATIENTS WITH DENTAL INSURANCES

- I **understand that my insurance policy is a contract between My Insurance Company and Myself**. Divine Dental Center and its employees are not parties to my contract with my insurance company.
- **I understand that I am ultimately responsible for any and all balances, even if my insurance company agrees to pay a balance and later does not pay.**
- I understand that I may be given the option of only paying my **estimated** portion (that portion not covered by insurance) at the time of services. **As a courtesy, the office will send my claim to my insurance company. If my insurance fails to pay their estimated portion after 45 days, the balance is my responsibility and payment is due in full.**
- I understand that if my first visit is an emergency visit, I will be responsible for payment of services in full at the time of the visit. As a courtesy, Divine Dental Center may provide to me the necessary documents to file to my insurance company for reimbursement.

I have read, understand and agree to the above Divine Dental Center Office Financial Policy.

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Signature of Patient/Responsible Party Date