

Financial Policy

Thank you for considering Elite Endodontics for your treatment. We pride ourselves in patient-centered care. In our continuing efforts to provide comprehensive dentistry to you, our valued patients, we ask that you become acquainted with our financial policy. If at any time you have any questions, please feel free to ask one of our team members, so that we may better serve you. All recommended treatments are in the best interest of our patients. We will assist you in your payment options to help you receive the highest quality of dental care treatment that is necessary for your needs.

Dental Insurance

We accept assignment of estimated insurance benefits as a courtesy to our patients. Please note that your dental insurance is a contract between you and the insurance company. Our usual and customary fees, which are based on geographical area, are a reflection of our commitment to excellence. All estimated co-pays and deductibles are due at the time of service. Balances remaining after 60 days will begin to accrue a finance charge of 1.5% from the date of service on the unpaid balance of your account. In the event that insurance does not cover your treatment or is cancelled/terminated for any reason, or cannot be verified for any reason, the patient or responsible party will be responsible for the entire fee amount including the insurance portion.

Emergency Patients

Please note that our policy required verification of insurance. In the event that we are not able to verify your insurance information, payment will be due at the time of service. We will assist you in submitting a claim to your insurance company, so that the insurance company will reimburse you directly for your treatment. If the insurance payment is sent to our dental center, any applicable credit will be refunded to the patient.

Appointments Cancellation Policy

We reserve appointment times especially for you and your dental care needs. We strive to give each patient a courtesy call one to two days in advance of their scheduled visit. However, you are expected to keep your appointment time with or without a courtesy call. Therefore, we ask kindly ask that you give 24-hour notice if you are unable to keep your appointment. **Please note that if 24-hour notice is not given, there may be a \$75 broken appointment fee.** A broken appointment is a loss to yourself, your dentist, and to another patient who could have had that appointment time. **We reserve the right to terminate your relationship with our office after 2 (two) or more broken appointments without 24-hour notice.**

Patient Identification

We require a **picture** I.D. for all patients over the age of 18.

Method of Payment

For your convenience we accept Cash, ATM/Check cards and all Major Credit Cards (American Express, MasterCard, Visa, Discover), and Checks (with proper I.D.). There will be a fifty dollar (\$50) returned check fee applied to your account in the event your check is denied by the bank. Payment will be expected within 48 hours of notice from the bank, in cash or by credit card. As an added courtesy, we also offer a revolving line of credit through a third party (upon credit approval). This line of credit allows you to start treatment today and spread payments over a comfortable period of time.

*Our fees are explained and disclosed prior to receiving any treatment plan or services. Our fees are reasonable and commensurate with the knowledge, skill, experience and service provided by our dentist and staff.

Deposit

We may require a deposit to be made to hold any appointment time.

Refund Policy

1. Once Services are performed, refunds cannot be made for those services.
2. All electronic payments will be refunded within **ten (10) business days**.
3. All cash and check payments will be refunded, by company check, within **thirty (30) business days**.
4. A "Release of Claims" form must be signed before refunds are issued.

Agreement to pay

In the event there is a default of payment on any balance due, Elite Endodontics will make all necessary collection efforts to secure the balance due. This may include reporting a delinquency to a credit report agency and taking legal action. Any additional costs incurred will be charged to the patient or responsible party.

By signing for, and accepting this policy, I understand that I am entering into a contractual relationship with Elite Endodontics for professional care and that I am ultimately responsible for all fees incurred for my treatment regardless of payment or denial of my insurance claims(s) by my insurance company.

I have read, understand, and agree to all stated within the Financial Agreement.

Patient Printed Name: _____

Patient Signature: _____ Date: _____