ASPEN LEAF DENTISTRY, P.C. FINANCIAL POLICY

We realize that each person's financial situation is different, and in today's world of rising costs we are trying to keep fee increases to a minimum.

1. Payment in full is expected at the time services are rendered. Fees for your treatment needs will be given to you prior to treatment along with a written financial arrangement.
2. We are happy to cooperate with families who are covered by dental insurance.
3. Patients having dental insurance will be required to pay the DEDUCTIBLE and ESTIMATED PATIENT PORTION of the fee for each appointment. We can only estimate what your coverage will be. You will also be responsible for any remaining balance after your insurance company has paid the claim. On average, insurance companies pay between 52% - 70% of dental treatment.
4. While the filing of insurance claims is a courtesy that we extend to our patients, WE MUST EMPHASIZE that as oral healthcare providers, our relationship is with you, the patient, and not the insurance company. If we do not receive reimbursement within forty-five (45) days, payment becomes your responsibility.
5. We currently accept cash, checks, Visa or Master Card. We also have many resources to help finance certain treatment needs.
6. We pride ourselves on seeing one patient at a time. We respect your busy schedule and ask that you be prompt with your appointment.
7. Your appointment time is reserved specifically for you at your request and because you are important to us. Certain appointments may require a deposit which will be applied to services rendered at that appointment. A minimum fee of $50 will be charged for any appointment cancelled or rescheduled with less than two working day's notice. Please help us to avoid charging this fee by keeping your scheduled appointment time.
8. There will be a $35 charge for any returned checks with insufficient funds and all associated legal fees.

Unless I have paid at the time of treatment, I hereby authorize direct payment of dental benefits from my insurance company to Aspen Leaf Dentistry, P.C. for services rendered. I understand that I am financially responsible for any balance not covered by the insurance company. I also understand that Aspen Leaf Dentistry, P.C. is not required to wait for insurance reimbursements where coverage is uncertain or denied. I further understand that Aspen Leaf Dentistry, P.C. reserves the right to terminate our healthcare provider-patient relationship in the event that my account becomes over sixty (60) days delinquent, and impose interest at eighteen percent (18%) per annum, in addition to being entitled to collect all reasonable costs and expenses of collection, including but not limited to reasonable counsel fees.

The undersigned agrees that they have read and understand this entire agreement and have not signed below in reliance upon any verbal or written promise, condition, or representation made by any person.

**Signature:_____Date:_____**