Financial Policy

Thank you for choosing Oak Grove Dental Center as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as 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. All patients must complete our information and insurance form before seeing the doctor.

Regarding Payment

We accept the following forms of payment: Cash, Check, Visa, MasterCard, Discover, American Express, and Care Credit. **My preferred method of payment is (circle one):**

Cash Check Credit/Debit Care Credit

Payment in full is due at the time services are rendered. *Initial:* _____

If dentures, partial dentures, crown and bridge are to be fabricated by a dental laboratory, a **50% deposit** will be required at the time of the first appointment. The remaining balance is due at the time the prosthesis is cemented or inserted.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing receptionist.

Checks that are returned to our office from your financial institution are subject to a $30.00 returned check fee. This fee covers the processing fees that are charged to our office.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, we may bill you for the balance. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy.

Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

Your complete insurance information must be presented at the time services are provided. Most benefits will be verified before your insurance company can be billed.

All coinsurance and deductibles are due at the time of service. *Initial:* _____

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Any unpaid balance will be assessed a 2% monthly finance charge after 30 days.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____
Patient Name (Please Print)

_____
Signature of Patient or Responsible Party

_____
Date