Financial Policy

Payment for services is expected by the completion of treatment. For patients with dental insurance, this would be the balance not paid by your insurance company. We submit electronically to them at the time of the appointment and will be able to tell you your balance depending on your insurance company. Please be prepared to pay your co-pay at that time. Payment may be made by cash, check, or credit card.

We are participating with the local Blue Cross, Blue Shield (Excellus) insurance only and follow their fee schedule for our patients with this insurance.

Our office submits claims to most insurance companies. Most but not all insurance companies send payments to our office. For cases that may incur larger balances we will preauthorize this treatment with your insurance company. Since insurance companies can take months to pay, we require a down payment for cases that have laboratory fees. We will be happy to assist you in any way with your insurance but please be aware of your policy's benefits and restrictions. Most policies have a maximum dollar amount each year and they only pay a percentage of that amount per procedure.

If a large balance cannot be paid at the end of treatment, payment arrangements need to be made before treatment begins.

In the situation where children of divorced parents are patients, the parent who brings the child in for his/her appointment is considered the responsible party.

A broken appointment is any appointment not cancelled within 24 hours. After one broken appointment, a $50.00 charge will be made for an appointment with the hygienist and a $100.00 charge for an appointment with the dentist. This charge must be paid in order to schedule future appointments.

You are responsible for your account. Accounts overdue by 60 days will be charged a monthly billing charge of $5.00.

If the occasion arises that the account is past due or has to be sent to collection, the patient will be responsible for the balance plus any late fees and the costs incurred in the process of collection.

Signature of Patient or Guardian_____

Date_____