SIGMA DENTAL SPECIALISTS

Financial Policy

Thank you for choosing our practice to serve your dental needs. Please take the time to read the following, initial each section, and sign and date the bottom of this form.

_____ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_____ Insurance balances are ultimately the patient's obligation. We will file with most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow-up with your insurance carrier to ensure proper payment.

_____ Some of your treatment may <u>not</u> be covered by your insurance carrier. The cost for such charges will be your responsibility.

_____ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

_____ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm may result in loss of appointment time.

_____ There will be a fee of $75 for failed appointments or those rescheduled without 48 hour notice.

_____ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

Interest charges of 1.5% per month
18% APR collections fees (up to 25% of the full balance)
Legal fees for collection services

_____ _____
Signature of Patient, Parent or Guardian Date

_____ _____
Print Name Witness