

**Weston Dental Care**  
**FINANCIAL AGREEMENTS AND TREATMENT POLICY**

We feel that everyone benefits when there is definite and clear understanding of our treatment and financial policies prior to treatment. They are intended to allow us to be fair to our entire family of patients and help control administrative cost.

**APPOINTMENT**

Please be on time for reserved appointment. We have exclusively reserved the Doctor, Staff, and Facility for your personal dental care. We would appreciate your consideration in giving our office a 48 hour notice, if for some reason you are unable to keep your reserved time. This is so that we may effectively re-utilize the time with the Doctor or Hygienist. If you do not show up for an appointment you made, without sufficient notice, we reserve the right to charge a \$50 per ½ hour broken appointment fee.

**FEES**

The fees for quality dental treatment are based on the treatment rendered and the time needed to complete the treatment. Our office believes that the fees are a fair representation of quality care we provide in-step with dental standards.

**PAYMENTS**

1. Your initial exam payment is due at the time of service.
2. We accept cash, personal checks. Visa, Mastercard, Discover, and American express.
3. We offer an up to 24-month interest free payment plan to qualified patients.

**INSURANCE**

As a courtesy to you and for your convenience we will bill your insurance company for treatment rendered, provided we have current and accurate benefit coverage information. Please understand that your dental benefits program is a contract between you, your employer and your insurance company. We do not have a contract with your insurance company, therefore, we have to hold you responsible for the balance on your account. We will expect you to pay your deductible and out of pocket portions at the time services are rendered. In the event your insurance company overpays, we will gladly refund you promptly. If your insurance carrier does not make a payment within 45 days, you will be notified. At this time we will bill you for any outstanding balance. In this instance we will assist you in gaining reimbursement from the insurance company directly.

**COURTESIES**

For comprehensive treatment plans in excess of \$1000, a courtesy is available if the entire fee is paid at the time treatment is started. You will receive a 5% courtesy (this does not apply to outside financing i.e. unicorn) Senior Citizen Courtesy is available at 10% if the entire fee is paid at the time treatment is started.

**RETURNED CHECKS**

There is a \$25 fee for any returned checks.

**REQUEST FOR X-RAYS AND RECORDS**

There will be a \$25 fee per patient.

Our office would like to thank you for your time, cooperation and trust in us to deliver comfortable, safe and quality dental care to you, your family and friends. We also appreciate your understanding in the necessity of our financial guidelines and policies.

I have read, understand and will abide by the information concerning these office financial policies.

\_\_\_\_\_  
**Responsible Party Signature**

\_\_\_\_\_  
**Date**