NORTH HAMPTON DENTAL GROUP, P.C.

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OUR FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. We are committed to your comfort and treatment success. Your commitment to us includes prompt payment for treatment. The following is a statement of our Financial Policy which we ask you to read, understand, and sign prior to any treatment.

FULL PAYMENT OR CO-PAYMENT IS DUE AT TIME OF SERVICE
WE ACCEPT CASH, CHECK, CARE CREDIT or VISA/DISCOVER/MASTERCARD/AMERICAN EXPRESS
A FINANCE CHARGE OF 1.50% PER MONTH WILL BE APPLIED TO ANY BALANCE THAT IS OVER 60 DAYS.

REGARDING DENTAL INSURANCE

We usually accept assignment of dental benefits. Your benefits policy is a contract between you and your benefits company. We are not a party to that contract. We will submit claims on your behalf to your insurance company when you give us complete information which includes social security number, ID number, date of birth and group and policy number. Our computer only estimates your dental benefits. You are ultimately responsible for payment of all services provided. When we do not accept assignment of insurance, the balance is your responsibility whether your insurance company pays or not. Please be aware that some, and perhaps all, of the services provided may be non-covered services. All co-payments and deductibles are due at time of service. In the event that your benefit coverage changes, please notify us immediately.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment possible, and we feel that our fees are reasonable for the service we provide. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Every insurance company creates their own schedule of allowances for fees reflecting their own policies which have more to do with their own profit motives than actual fees charged.

MINOR PATIENTS

We ask that you accompany your minor children for their appointments as parental consent is required for treatment. The parent or guardian accompanying a minor is responsible for full payment.

MISSED APPOINTMENTS

Our appointment cancellation policy requires 48 hours notice. We charge a fee of $75 for appointments missed or cancelled without this required notice. If you are more than 10 minutes late for your appointment, we may need to reschedule. Please work with us to find appointment times that are mutually compatible.

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

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

X_____ Date _____

Signature of Patient or Responsible Party