

**Dana D. Keith, D.D.S., & Associates**  
**Financial Policy**

Thank you for choosing us as your oral care and treatment providers. We are committed to your treatment being a success. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment:

**Methods of Payment:**

Payment is expected at the time services are rendered for all patients unless another formal financial agreement has been made in advance with our office. We accept cash, personal checks, Visa, Master Card, American Express, Discover, and Debit cards for this purpose.

**Regarding Insurance:**

Your dental plan is designed to **SHARE** in your dental care costs. It may not cover the total cost of your bill. You are responsible to pay any deductible and percentage due **AT THE TIME OF SERVICE**. The percentage quoted you is an estimate and not a guarantee of payment from your insurance company. After the insurance claim has been settled, you will either be billed for the amount outstanding or reimbursed for an overpayment. If your insurance has not paid the claim within 45 days, the balance will be due in full by you.

In order for us to file claims on your behalf, you must supply us with all necessary insurance information. Please refer to your insurance manual for specific coverage.

**Minor Patients:**

The parent, guardian or adult accompanying a minor is responsible for full payment, their deductible, percentage or co-payment **AT THE TIME OF SERVICE**. For unaccompanied minors, non-emergency treatment will be denied unless charges have been prepaid or the minor comes prepared **AT THE TIME OF SERVICE**.

**Finance Charges**

Any account balance carried over 60 days will be subject to a late fee and a 1.5% interest fee per month (18% annually.) In the event the account is turned over to a collection agency, the patient will be responsible for any collection fees incurred at a rate of 35% of the total outstanding balance.

**Commitment to Appointment Policy:**

**48 hours** notice is required for canceled appointments. Missed appointments and canceled appointments with less than **48 hours** notice will be assessed a \$50.00 fee, payable immediately. We understand that conflicts occur, but the more notice given, the better chance we have to appoint another patient in need of dental care. We ask that you respect our schedule as we do yours by seeing our patients in a timely manner.

***I understand and agree to this financial policy.***

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office Signature

\_\_\_\_\_  
Date