OFFICE FINANCIAL POLICY

Our financial policy has been set up to prevent misunderstandings. We are committed to your treatment being successful. Thank you for choosing us as your healthcare provider.

1) Full payment is expected at the time of service.

2) We accept cash, check, visa/mastercard, discover and care credit.

3) Unless canceled at least 48 hours in advance, our policy is to charge for missed appointments at the normal rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

4) Returned checks are subject to a $25.00 service charge and will terminate your privilege to pay on future visits with a check.

5) Regarding insurance plans, the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to this contract. Please be aware that some, and perhaps all of the services provided may be non-covered and not considered reasonable or necessary under the dental insurance.

7) For any outstanding balance past 30 days a billing charge may be added.

6) It is understood and agreed that in the event any outstanding balance has to be referred to a collection agency or attorney for recovery, you will be fully responsible for all collection agency fees and attorney's fees.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. Please sign below.

Signature _____ Date _____

WILLIAM J. SCHOEPFEL, DDS

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