Dear Patient,

Thank you for choosing our dental office for your treatment. Our financial policy has been established to ensure that the best services can be provided to you and your family. Our hope is that any misunderstandings can be avoided.

To help keep our fees as low as possible, we ask patients to pay for services at the time of treatment. If you have dental insurance, your deductible and co-payment will be due at this time. For your convenience, we accept cash, check, Visa or MasterCard. In addition, we offer a financing option, through Care Credit upon request.

Due to constantly changing insurance contracts, benefits, and deductibles, we are only able to estimate your insurance coverage. If the insurance company pays less than expected, you will be charged the difference. Final responsibility for payment rests with the patient or patient's parent/legal guardian. Please remember your insurance policy is between you and your company and not between the insurance company and the dentist.

Furthermore, we would like to inform you that upon receiving claims, some insurance companies downgrade services such as fillings and crowns, leaving the patient owing the difference between these services. Please consult your insurance company with any questions.

A 1.3% monthly service charge (16% annual rate) may be applied to all overdue accounts after 30 days. If your insurance company does not pay in full within 90 days, the balance will be your responsibility. There is a non-sufficient check fee of $30 for all returned checks.

Any treatment fees quoted are honored for up to a three-month time period and may change after that due to changes in costs of dental supplies.

If you need to cancel or move an appointment we will need 24 hours advance notice. If you fail appointments, or give short notice to cancel appointments, you may be subject to dismissal.

I have read and understand this Financial Policy and acknowledge that I am responsible for payment of all fees, whether or not they are covered by insurance. I agree to assign insurance benefits to Dr. Luke W Burgher, D.D.S.

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Patient or authorized representative signature Date

_____

Printed Name

Thank you,

Burgher Family Dentistry