Financial Policy

Thank you for choosing the office of Drs. Scott and Williams for your dental needs. In an effort to provide quality care to our patients and to avoid any misunderstandings, we would like to inform you of our office policy regarding payment for services rendered.

Payment is expected at the time treatment is performed. As a courtesy to our patients with dental benefits, we will submit your claim to your insurance company. Any portion not expected to be covered by these benefits is the **responsibility of the patient and due at the time the service is rendered**. This amount will include deductibles and co-payments. If benefit amounts are less than expected, you will be billed for the difference and payment is due within 30 days.

Dental benefits are contracts between the **policyholder** and the **insurance company**, **not** our office. We will make every effort to assist you with any benefit questions, however we suggest that you be aware of what benefits you have available. Ultimately, you are responsible for the balance.

Marital status is not a consideration under any circumstance. Decreed custody or lack thereof, does not alter financial responsibility. The parent accompanying the child/minor on the day of service will be considered the responsible party. We will gladly provide you with copies of statements, which you may need to provide the other parent for reimbursement.

There is a $25.00 charge for returned checks. If a check is returned and not paid within 7 days of return date, legal action may be taken for collection. Any costs associated with collection of returned checks will be assumed by you.

In the event your account becomes delinquent, you will be responsible for collection fees, attorney fees and court costs.

For your convenience, we accept:

Cash, Check, Visa, MasterCard, Discover,
American Express

Broken Appointment Policy

We require 24 hours notice for cancellation or rescheduling of an appointment. If 24 hours is not given, a $25.00 broken appointment fee may be charged.

Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

By signing below, you understand and accept the terms of our **Financial Policy**, **Broken Appointment Policy**, and acknowledge receipt of our **Notice of Privacy Practice.**

_____ _____

Signature (*Patient, Parent, or Guardian) **Print Name**

_____ _____

Email Address **Date**