

North Dental Professionals Financial and Appointment Policy

Accepted Payment Types

We accept cash, check, most major credit cards and Care Credit.

We ask all of our patients to pay for services the day of treatment, including those with dental insurance. By paying for treatment on the day of service it helps us to reduce bookkeeping and billing expenses that would otherwise increase the cost of your care.

Insurance Patients

The patient or guarantor is ultimately responsible for all account balances regardless of insurance coverage.

Not all services are covered benefits with dental insurance companies. Your employer has selected your level of coverage.

We submit insurance claims as a patient courtesy, however that contract exists between the patient/ insured and the insurance company. We try to help all patients receive the maximum benefits their plans will allow for the treatment they need. Our business is providing excellent dental care. When or if there are insurance difficulties, please know that we are working on your behalf and pledge to do our best to support you.

To speed up insurance processing, it is important that you are familiar with your insurance coverage and provide us with accurate information. Please bring current dental information with you to your appointment.

Broken Appointment

In an effort to keep dental costs down while maintaining a high level of professional care, we respectfully request a 48-hour cancellation notice. Your scheduled time is reserved for you and the doctor or hygienist. For this reason, a cancellation fee of \$50 per hour of your appointment will be charged if 48-hour notice is not given. We appreciate your efforts to keep scheduled appointments.

Patient agreement

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered, as well as any finance charges, collection costs or multiple billing charges. I have read the financial policy for this office and I understand my obligations.

I authorize the release of any information relating to any dental claim. I leave my signature on file for future claims that relate to myself or minor children.

Patient signature _____ Date _____

(if under 18, signature of parent or guardian)