FINANCIAL POLICY

We feel strongly that our patients deserve the best care. In an effort to provide high quality care, we would like to share information with you about financing health care. We hope that by providing you with the following information, we can prevent misunderstandings and that you will be comfortable discussing financial and insurance matters with us.

1. We ask that you pay in full at your first visit. If you have insurance, please pay that portion which insurance does not cover. We accept **VISA, MasterCard, Discover, American Express and Care Credit** for your convenience.
2. Remember that, if you have insurance, the insurance contract is between the patient and the insurance company. The patient is responsible for all account balances, even with insurance benefits. We will bill your insurance as a courtesy to you, but we cannot guarantee your benefits. If your insurance provider informs us of benefits that you are entitled to, we will advise you of the same, however we cannot be responsible for inaccurate information provided by your insurance company, or for payment or nonpayment of claims.
3. Within 30 days of service, the balance should be paid in full. Compounded Interest will be charged at 18% per year (1.5% per month) on balances over 30 days past due.
4. Many insurance plans cover a certain percentage of the fees. Normally, the insurance company will cover the "usual and customary fees". These benefits are determined by how much your employer paid for the plan. Your insurance, as a result, may cover less than you thought they might have. Please be familiar with the benefits provided by your plan.
5. For our patients without insurance coverage, we offer a 7% discount for services paid by cash or check. Seniors (65 years and older) without insurance are eligible for a 10% discount if paid in full by cash or check at the time of service.
6. The age of majority is 18 years old. The parent that brings in the minor child is responsible for payment.
7. Past due accounts will be sent to a collection agency at our discretion. We charge **$25** for returned checks.
8. If you find it necessary to reschedule or cancel an appointment, please contact us **2 business days (M-Th) in advance** so that your time may be utilized by another patient in need. Failed appointments, as well as, appointments changed or cancelled without 2 business days' notice will result in a **$50 charge per hour for hygiene visits and $100.00 charge per hour for any visit for dental treatment. _____(Please read and initial)**

I authorize insurance benefits to be paid directly to Dr. Kelley. I also give permission for the doctor to release information in order to process the claim. I agree that I am responsible for all unpaid balances.

Signature:_____

Printed Name:_____**Date:**_____