Island Dental Associates

OFFICE FINANCIAL POLICY

THANK YOU FOR CHOOSING OUR OFFICE AS YOUR DENTAL CARE PROVIDER. WE ARE COMMITED TO PROVIDING YOU WITH THE HIGHEST QUALITY LIFETIME CARE SO THAT YOU MAY FULLY ACHIEVE OPTIMUM ORAL HEALTH. EVERYONE BENEFITS WHEN OFFICE AND FINANCIAL POLICY ARRANGEMENTS ARE UNDERSTOOD. IN ORDER THAT WE MAY HAVE A DEFINITE UNDERSTANDING IN REGARD TO THE PAYMENT FOR DENTAL SERVICES, THE FOLLOWING IS OUR POLICY.

Payment is due at the time of service provided. We accept cash, cashier's check, Visa, Mastercard, Discover, American Express, care credit and Citi health. Returned checks will be subject to additional fees. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of dental insurance. There will be a charge of $50 for patients that do not show for their appointment date and time. This will apply to same day cancellations. As a courtesy to you we will help you process all your insurance claims. We ask that you pay the deductible and co-payment which is the estimated amount not covered by your insurance company.

We must emphasize that this is only an estimate and all charges you incur are your responsibility regardless of your insurance coverage. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer and the insurance company. Our office is not a party to that contract. We will cooperate fully with the regulations and request of your insurance company that may assist in the claim being paid. However, this office will not enter into a dispute with your insurance company over any claim. Once insurance has paid their share, a statement will be sent to you for any remaining balance and will be due upon receipt. If your insurance company has not made a payment within 60 days, the unpaid balance becomes your responsibility and is subject to finance charges and collection process.

Patient Signature ______________________________

Date____________________

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