

Stephen C. Noble, DDS

Financial Policy

Thank you for selecting our office as your personal dental care team. It is our mission to deliver the finest and most comprehensive care available today. Please review the following policies regarding treatment, insurance, appointments and fees.

Treatment:

We will always recommend treatment based on optimal care and necessity. Following your visit, we will provide you with a plan for treatment and discuss with you the costs involved.

Insurance:

As a courtesy to our patients, we will submit all insurance claims on your behalf; including any follow-up processes that may be necessary. Ultimately, however, you are fully responsible for the charges for the treatment rendered. **Your insurance may not cover** the services or may only **partially** cover them and any **estimate** given by this office should be considered to only be a guideline until payment is received from the insurance company and the patient's account is reconciled. This office can make **no guarantee** of the actual payment your insurance company may make. At no time will we change treatment codes or dates of service to manipulate your insurance benefits; this is insurance fraud.

Missed Appointments:

When we schedule your appointment, we are reserving that time exclusively for you. Please give us at least 24 hours' notice when you must cancel an appointment. We reserve the right to charge a fee for failed or broken appointments not meeting the requested 24 hours' notice.

Payment:

Payment is due at the time of service. For your convenience we accept cash, personal check, Visa, MasterCard, Discover and American Express. In addition, we offer Care Credit for those requiring extended payment options. Please inquire with office staff to obtain more information regarding Care Credit's terms, conditions and application process.

Administrative Fees (If applicable):

Returned checks are subject to a fee of **at least \$35**. Cash or credit card may be required to pay the remaining bill.

I understand that I am responsible for all fees incurred for dental treatment and agree to pay according to the options provided. I understand and agree that **any account balance over 60 days will incur a 1.5% per month finance charge and that additional charges may occur if the account is turned over for collection.**

Signature: _____ Date: _____
(Patient/Parent/Legal Guardian)

