Dripping Springs Family Dentistry, Inc.

Financial Policy

Proudly serving Dripping Springs and Surrounding Communities for over 15 years!

We value you as a patient and are committed to providing you with the best possible dental care. We want you to have complete understanding of your financial responsibilities for the services we provide. To assist us in achieving these goals, we ask that you review our financial policy.

Unless our authorized staff has approved payment arrangements in advance, payment in full will be due at the time services are rendered. We will be happy to help process your claim for reimbursement or you may assign your primary insurance benefits to the doctor for partial payment towards the services rendered. This can be done after we have had the opportunity to verify your primary insurance benefits.

At the time of the appointment, you will be expected to pay your deductible as well as any portion of the treatment fees that we ESTIMATE will not be covered by your insurance policy. Because of insurance policy changes and/or necessary changes in treatment plans, your dental coverage may vary from a treatment calculation or your carrier's pre-estimate. If your insurance company has not paid the full balance of the claim within 60 days from the treatment date, you will be responsible for paying the balance. **Please remember that your insurance is a contract between you and your insurance company and/or employer. Our dental practice is not a party to the contract.** We recommend that any questions regarding the amount of insurance coverage for the specific treatment be discussed with your insurance company or your employer.

If your check is dishonored or returned for any reason there will be a **$45.00** processing fee. Your payment by check is your acceptance of this agreement and its terms.

We do understand when emergencies surface and you need to cancel an appointment. We request that when you do cancel, you give at least **48 hours of notice**. Please understand that if you cancel or "no show" on two consecutive visits, we will charge your account **$45.00.**

All treatment charges are the responsibility of the patient or responsible party regardless of insurance coverage. In the event of non-payment, the patient or responsible party agrees to pay all the costs of collection including but not limited to attorney fees, court costs, collection agency fees, etc.

I have read and understand the financial policy of this practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of Patient/Parent/ Guardian _____*Date*_____