Financial Policy

We are honored that you have chosen us for your child's dental care. We wish to establish a long and pleasant relationship with you and your child. We understand that filing dental insurance can be very complicated and time-consuming. We want to assist you in any way possible to receive the maximum benefit from your insurance. Your understanding of and cooperation with the following guidelines is appreciated.

We are contracted as a Preferred Provider for the following dental insurance companies:

- Aetna
- Cigna
- FEP Blue Dental
- Metlife
- United Concordia (Tricare)
- Blue Cross/Blue Shield of Alabama
- Delta Dental
- Guardian
- Southland
- United Healthcare

All applicable deductibles, co-pays, and coinsurance amounts are due at the time services are rendered. We accept cash, check, Master Card, Visa, Discover, and most forms of mobile payments (Apple Pay, ect). Some dental services may not be covered by your contract. In the event that a given procedure is not covered, payment for these services is your responsibility. Balances not paid in a timely manner will be turned over to collections.

If your insurance is not with one of the above companies:

> Please check your contract carefully to determine if you are required to see a preferred provider for that company. Understand that if you choose to see a non-preferred provider, your insurance may not pay the full amount or pay at all. Your insurance is a contract between you and your insurance company. Our office is NOT a party to that contract.
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> While the filling of insurance claims is a courtesy that we gladly extend to you, all charges are ultimately your responsibility from the date services are rendered.

In order to facilitate accurate and prompt reimbursement, we request that you give us complete and correct information. If you have any questions regarding your insurance coverage or our financial policy, please do not hesitate to ask.

Cancellation Policy

Any appointment cancelled or rescheduled less than 24 hours in advance will count as a missed appointment. If a patient misses two appoints, a $50 charge will be applied to his/her account. After three separate missed appointments, he/she will be subject to dismissal from the practice.

By my signature, I acknowledge that the above financial policy has been thoroughly explained to me in writing and I understand and agree to comply with said policy.

Responsible Party's Signature ______________________________ Date _____/_____/_____

Staff Signature ______________________________ Date _____/_____/_____