Oceanside Family Dental, PC

FINANCIAL POLICY

In an effort to provide quality dental care to our patients and to avoid any misunderstandings, we would like to inform you of our office policy regarding payment for services rendered.

Payment is expected at the time treatment is performed. As a courtesy to our patients with dental benefits, we will submit your claim to your insurance company. Any portion not covered by these benefits is the responsibility of the patient and due at the time service is rendered. This amount will include deductibles and co-payments.

Your dental benefit is a contract between you and your insurance company. We will make every effort to assist you with any benefit questions, however, we suggest that you be aware of what benefits you have available. Our office is not responsible for your dental benefits or it's limitations.

Marital status is not a consideration under any circumstance. Decreed custody or lack thereof, does not alter financial responsibility. The parent accompanying the child/minor on the day of service will be considered the responsible party. We will gladly provide you with copies of statements, which you may need to provide the other parent for reimbursement.

There is a $25.00 charge for returned checks. There is a 1.5% finance charge (18% annually) which will be added to any balance over 60 days. In the event of default you are responsible for interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this debt.

For your convenience, we accept: Cash**, Check, Visa, MasterCard, Discover and Care Credit**
(A dental credit card. Ask our staff for an application and details.)

BROKEN APPOINTMENT POLICY
Our office requires 24 hours notice for cancellation or rescheduling of an appointment. If 24 hours is not given, a broken appointment fee will be charged based on the length of the appointment.

NOTICE OF PRIVACY PRACTICES
A copy of this office's notice of privacy practices will be provided at a cost.

DENTAL MATERIALS FACT SHEET
A copy of this office's Dental Materials Fact Sheet will be provided.

By signing below, I understand and accept the terms of the office's **Financial Policy** and **Broken Appointment Policy.**

Signature of Responsible Party:_____ **Date:**_____
Patient, Parent, or Legal Guardian