

Capitol Square Dental

Financial/Insurance/Billing Policy

We appreciate your selection of our office to serve your dental health needs, and are dedicated to the proposition that dentistry can be a pleasant experience. We are also committed to providing you with the best dental care possible.

In order for us to provide that care, we will be happy to help you maximize your insurance benefits by submitting your claims for you. While filing of insurance claims is a courtesy to our patients, all charges remain your responsibility from the date the services are rendered. We will be happy to provide you with an estimate in advance, and ask that all co-payments for service be paid at the time of treatment. Please note that our estimates are subject to error and do not reflect the actual amount due, but an approximate amount of your personal treatment costs. If there is an overpayment, a refund will be sent to you; if there is an underpayment, the balance will be billed to you.

Statement balances are due at the time of receipt. A service charge of 1.5% per month will be added to accounts with an outstanding balance of 60 days or older. Please be advised that you may be responsible for all collection charges and/or attorney fees, if your account is placed for collection. Returned checks will be subject to a fee of \$25.00. We do understand that emergencies can occur, and request that you contact our office to avoid any misunderstandings about your account.

We respectfully ask our patients to be prompt and keep their scheduled appointments. We will try to remind you by telephone prior to your appointments, but please do not rely upon this courtesy. If you are unable to keep your scheduled appointment, we require a minimum of 48 hours to avoid a possible cancellation charge to your account.

Our goal is to provide you with the most comfortable care in a positive environment, while helping you understand your financial responsibilities. If you have any questions, please feel free to ask any member of our staff.

I have read the above and agree to the terms.

Signed _____ Date _____
(Parent or Guardian if a minor)