Dana D. Keith, D.D.S., & Associates
Financial Policy

Thank you for choosing us as your oral care and treatment providers. We are committed to your treatment being a success. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment:

Methods of Payment:
Payment is expected at the time services are rendered for all patients unless another formal financial agreement has been made in advance with our office. We accept cash, personal checks, Visa, Master Card, American Express, Discover, and Debit cards for this purpose.

Regarding Insurance:
Your dental plan is designed to **SHARE** in your dental care costs. It may not cover the total cost of your bill. We do ask for payment in advance, and will help you file the necessary paperwork and documentation to get the maximum benefit reimbursement from your insurance provider. We request that your insurance company send reimbursement checks directly to you.

In order for us to file claims on your behalf, you must supply us with all necessary insurance information. Please refer to your insurance manual for specific coverage.

Minor Patients:
The parent, guardian or adult accompanying a minor is responsible for full payment, **AT THE TIME OF SERVICE**. For unaccompanied minors, non-emergency treatment will be denied unless charges have been prepaid or the minor comes prepared **AT THE TIME OF SERVICE**.

Finance Charges
Any account balance carried over 60 days will be subject to a late fee and a 1.5% interest fee per month (18% annually.) In the event the account is turned over to a collection agency, the patient will be responsible for any collection fees incurred at a rate of 35% of the total outstanding balance.

Commitment to Appointment Policy:
48 hours notice is required for canceled appointments. Missed appointments and canceled appointments with less than **48 hours** notice will be assessed a $50.00 fee, payable immediately. We understand that conflicts occur, but the more notice given, the better chance we have to appoint another patient in need of dental care. We ask that you respect our schedule as we do yours by seeing our patients in a timely manner.

I understand and agree to this financial policy.

_____ _____
Signature of patient or responsible party Date

_____ _____
Office Signature Date