



Office Financial Policy

Our office is committed to providing you with the best possible care. Please understand that payment of your bill is also considered part of your treatment. We have instituted the following financial policy, which we require you to read and sign.

- Co-Payment for services are due the day of treatment.
- Any portion not covered by insurance is the patient's responsibility.
- Statements are sent out monthly. After 3 months of no payment/arrangement accounts are forwarded to collections.

Your insurance is a contract between you and your carrier. We are not party to that agreement. All patient out-of-pocket fees are due at the time services are rendered. As a courtesy, our office can perform an insurance pre-determination on any major services. We will submit your claim to your insurance carrier, however, dental insurance policies are ever changing. We do our best to give you an **estimate** of what your out-of-pocket expenses will be.

For your convenience, we accept Cash, Checks, Credit/Debit Cards, Discover and Care Credit.

Please ask our front office staff any questions or concerns regarding payment or financial arrangements prior to your scheduled appointments.

I have read and understand the Financial Policy. By signing, I agree to the policy and give permission to Oakmont Advanced Dentistry to bill my insurance if applicable.

Patient/Guardian Signature: _____

Date: _____