FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign before seeing one of our dental professionals.

*FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECK, AND ALL MAJOR CREDIT CARDS. WE ALSO OFFER CARE CREDIT, WHICH IS AN EXTENDED OUTSIDE PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

REGARDING INSURANCE

Understand that, regardless of any insurance status, you are responsible for the balance due on your account. Your insurance policy is a contract between **you** and **your insurance company**.

We require any estimated co-payments, deductibles and any services not covered by your insurance plan, be paid at the time the service is provided. We cannot bill your insurance unless you provide us with all the necessary insurance policy information. If your insurance has not paid within 60 days, the balance will automatically transfer back to your account. Please be aware that some, and possibly all, of the services provided may be non-covered services under the terms of your particular dental insurance plan.

PAYMENT PLANS

NO "in house" payment plans are available. Sheridan Family Dentistry has partnered with Care Credit, a patient financing company, to offer our patients 0% interest financing, with credit approval.

MISSED APPOINTMENTS

Cancellations require **24 hours advanced notice.** Please help us serve you better by keeping scheduled appointments. Excessive cancellations and no shows will result in dismissal from the practice.

REFUNDS

Refunds for overpayment will be sent after all treatment is completed and insurance has been collected.

I HAVE THOUROUGHLY READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS POLICY.

_____

Print Name

_____ _____

Signature **Date**