GEORGE A. TURNER, D.D.S.

FINANCIAL POLICY

Thank you for choosing us for your dental care provider. Our dental team is committed to providing you with the highest quality of dental treatment. The following is a statement of our Financial Policy which we ask you read and sign prior to any treatment. Please understand that payment of your bill is considered part of your treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/DISCOVER

Regarding Insurance:
If you have private (indemnity) insurance then this insurance policy is a contract between you and your insurance company. We are not a party to that contract. The balance is your responsibility whether your insurance company pays or not. **Please be aware that some of the services provided may be non-covered services depending on the limitations, exclusions and provisions of your particular policy. Knowledge of these limitations, etc. is the patient's responsibility.**

If you are on an insurance plan for which we are a PARTICIPATING PROVIDER, **all co-pays and deductibles are due at the time of service.** If you are unable to furnish us with insurance information prior to your visit you will be asked to pay in full for that day's visit.

If your insurance company is waiting on more information from the insured (you) before they pay us and the balance is past 45 days, the balance will be your responsibility and will be payable at that time.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of "usual and customary" rates, or whether or not they agree with any treatment provided.**

Billing Statements:
A re-billing fee of $5.00 is charged when a second statement is sent. If no response, the account is sent to collections.

Missed Appointments:
Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $60 p/hour. Please help us serve you better by keeping scheduled appointments. Our staff will make every effort to remind you about your appointment, usually the day before. We ask that you give us permission to leave a voice message confirming the time and date of your appointment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy. I also understand and agree that if my insurance company declines payment on any treatment, I agree to pay the remaining balance immediately and in full.

_____ Date_____

Printed Name of Patient

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Signature of Patient or Parent/Legal Guardian