Salmon Dental Center PLLC
Patient Treatment and Financial Policy

Thank you for choosing our office for your dental care. We are committed to providing the highest quality treatment to help you achieve and maintain optimal oral health for life.

Payment Options:

1. **Cash Payments** including personal checks and money orders are accepted. We offer a **5% pre-payment courtesy** for payment in full upon scheduling for patients without insurance.
2. **Visa, MasterCard, Discover Card** and **Debit Cards** are accepted. We offer a **2% pre-payment courtesy** for payment in full upon scheduling for patients without insurance.
3. **Financing through CareCredit, a third party, is available upon request and approval on qualifying purchases.**

Please note: Payment in full or estimated insurance co-payment is due at the time of service.

Note: Returned checks incur a $25 fee. Balances over 45 days are subject to finance charges and late fees. Accounts unpaid after 90 days may be sent to collections and charged a $35 processing fee.

Do you have insurance?

- As a courtesy to you, we will file ALL insurance claims.
- Please be aware that our providers are **out-of-network** with all insurance plans, excluding specialists.
- We recommend that you contact your insurance provider directly to inquire about your benefits.
- We may provide you with an insurance estimate, however it is not guaranteed that your insurance will pay exactly as estimated.

Minors accompanied by the parent or legal guardian:
A parent or legal guardian must provide treatment consent and arrange payment before the appointment. Full payment is due at the time of service. Non-emergency treatment may be denied if these steps are not completed.

Regular Visits:
Our office practices *The Universal Standard of Care* which includes Comprehensive Examinations, Radiographs, and Hygiene care. We encourage our patients to adhere to the recommended visits. **Emergency visits will be limited to two consecutive appointments when the recommended standard of care is not followed.**

Appointments/Cancellations:
We see patients by appointment and consider each one a mutual commitment. If you need to cancel, please notify us at least **24 hours in advance** (except for emergencies) so we can offer the time to another patient.

A **$25 fee** will be charged for missed appointments or cancellations.

Consent: I, (Please print name) _____, have read, understand, and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Patient/Parent Signature: _____ **Date: _____**