Oak Cliff Dental Center
Financial Policy

Patient Name: _____

Dear Patient,

Thank you for choosing Oak Cliff Dental Center as your dental care provider The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to maintain your dental health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our office manager.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the dentist.

Payment for services is due at the time services are rendered. We accept cash and credit cards. We will be happy to process your insurance claim for you as long as you provide us with adequate information. However, you must understand the following:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.

2. All charges are your responsibility, regardless of whether your insurance company pays. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services they will not cover.

3. Fees for the services, along with unpaid deductibles and co-payments are due at the time of treatment. We accept cash, checks and credit cards (MasterCard, Visa, Discover and American Express).

4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help expedite the processing of your claim.

5. If the insurance company does not pay in full within 45 days, we require you to pay the balance due with cash, check or credit card.

6. You will be responsible for notifying us of any changes in your address, job status, insurance status and availability of benefits immediately. A failure to do so may result in a different balance of which you will be responsible.

Please note that unless canceled at least 24 hours in advance, you may be charged for missed appointments at the rate of $25.00. Please call if you have to reschedule.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing us as your dental provider. We appreciate your trust and the opportunity to serve you.

Patient's Signature: _____ Date: _____
(If patient is under 18, a parent or guardian must sign)

Parent's Name: _____