HERRICKDENTAL

OUR FINANCIAL POLICY

At Herrick Dental, we want all of our patients to be able to comfortably afford dental care. We proudly offer the following financial policy so that our patients have the opportunity to decide which payment option is best for their needs.

INSURANCE: Your insurance is a contract between you, your employer, and your insurance company. Herrick Dental will gladly work with you to help you get the maximum benefit available to you. Most insurance plans do not cover 100% of the treatment cost. Because of this, we ask that you pay your deductible as well as your **ESTIMATED co-pay** for the charges **on the day services are rendered**. We will estimate your coverage as closely as possible, but can make no guarantees as to what your insurance will pay. *If your insurance does not pay the estimated amount, the patient/policy holder is responsible for the balance.* After all treatment, we will promptly file and follow up on your dental claims to ensure that you receive the correct maximum benefits. We offer several financial options for your portion of diagnosed treatment so that your care is not compromised due to financial concerns.

PAYMENT OPTIONS

1. Cash or Check (there is a $35 fee for all returned checks)
2. MasterCard, Visa, Discover or American Express
3. Care Credit: A convenient line of credit can be arranged, on approval, for your health care needs.*
4. iCare Financial: Another Line of Credit that does NOT require a Credit Check.*

* Applies to specific services only. Please ask our business department for more details.

OUR APPOINTMENT POLICY

Because we reserve time specifically for you, it is vital that we receive appropriate notice for cancellations. If you find that you are unable to keep an appointment, please call our office 48 hours in advance. **Appointments not cancelled within 48 business hours, or no-show appointments could be subjected to a $50 fee.**

If a patient misses 2 or more appointments in a row, they may be asked to call us same day when they know they can make the appointment to avoid missed appointments that other patients may want or need.

FINANCIAL RESPONSIBILITY

I understand that payment is due at the time of service unless prior arrangements have been made. I am ultimately responsible for any balance on my account for services rendered.

I have read and fully understand the financial policies of this office.

Signature (Parent/Guardian if under 18):_____ Date:_____