PRESCOTT PERIODONTICS
& IMPLANT DENTISTRY, PLLC
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Finance Policy

Thank you for choosing Prescott Periodontics and Implant Dentistry for your personal dental care team. Our office is dedicated to providing long-term, optimal care for every patient. The following is a statement of our financial policy. Please read it and let us know if you have any questions. Our desire is to have complete transparency in care and fees.

OPTIONS FOR PAYMENT OF TREATMENT:

1. Non-Insurance Patients:
   Payment is expected at the time of service for treatment performed that day unless prior arrangements are made. For your convenience we accept cash, personal checks, money orders, American Express, MasterCard, Visa and Discover. Payment options are available and will be discussed when the treatment plan is presented.

2. Insurance Patients:
   Your insurance policy is a contract between you and the insurance carrier. It is your responsibility to know the details of insurance coverage; we will assist you in retrieval of benefits to the best of our abilities. Our office is only contracted as a Delta Dental Premier provider; although, as a courtesy to you, we will submit to all dental insurance plans on your behalf, and perform any follow-up processes that may be necessary. Our staff will make every effort to maximize your benefits. This office makes no guarantee of the actual payment made by your insurance company.

   For extensive treatment plans, the insurance benefit will be estimated to the best of our abilities. Payment in full is expected at the time of treatment, less any estimated benefit. Payment options are available and will be discussed when treatment is presented. If your insurance company has not paid their liability in full within 60 days, the balance becomes your liability.

Returned Checks: A $45 fee will be assessed to your account for each returned check. This fee and the original check must be paid in full with cash, credit card or money order, and must be paid in full before any future appointments

I understand that I am responsible for all fees incurred for dental treatment and agree to pay according to the option I have chosen. Any account balance over 60 days without payment will incur a 1.5% finance charge. Additional charges may occur if the account is turned over for collections.

Signature: _____ Date: _____
(Patient/Parent/Legal Guardian)