THE DENTAL CARE CENTER
General Family Dentistry

Thank you for choosing us for your dental care! We are committed to the success of your treatment and making your visit a pleasant and comfortable experience. The following is a statement of our Financial Policy, which we request you read and sign.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD.
*WE OFFER AFFORDABLE FINANCING OPTIONS FOR TREATMENT.
(See our receptionist for details)*

Regarding Your Insurance.....

Our practice gladly accepts Medicaid. Please bring your most current Medicaid Card and proper Identification to each appointment.

All co-payments and disallowed charges will be due at the time of service. If you are 21 years of age or older Medicaid requires that we collect your $3 co-payment at each visit.

Please be aware that some services provided may not be covered by North Carolina Medicaid. Our practice is committed to providing the best treatment for our patients. If a non-covered procedure is recommended, a non-refundable deposit may be required to reserve your appointment.

If insurance has not responded to a claim within 30 days of submittal or you were not eligible for dental benefits on the date of service, the full account balance becomes the account holder's responsibility. In the event that your account is placed in the hands of an agency for collection, the costs involved, including any attorney's fees, will be at the expense of the patient.

Regarding Missed Appointments...

When we schedule an appointment, that time is reserved just for you. If you must change an appointment, please give us at least 24 hours notice. We'll make every effort possible to verify your appointment at least two days in advance. Please help us serve you better by keeping scheduled appointments. If proper notice is not received, we reserve the right to require a non-refundable deposit to schedule future appointments.

By providing your email address, you enable us to notify you of upcoming appointments, as well as, special promotions our office may be offering!

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

X_____ Date _____
Signature of patient or responsible party

Printed Name _____