

**Thanks for choosing us as your dental provider. We at Pearly Whites Laser Dentistry** are proud to be a part of a team whose primary mission is to deliver the highest quality dental care available today. Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided.

**Insurance:** If you are not insured, payment is due in **full** at each visit. If you are insured by a dental plan but don't have an up-to-date insurance card, **payment in full for each visit is required until we can verify your coverage.** Please contact your insurance company with any questions you may have regarding your coverage. **It is your responsibility to know your benefits.** All patients must complete our patient information form before seeing the doctor. If you fail to provide us with the correct insurance information you will be responsible for the balance of a claim.

**Co-payments and deductibles:** All co-payments and deductibles are due at the time of service. Please help us in following your insurance guidelines by paying your co-payment at each visit as this arrangement is part of your contract with your insurance company.

**Non-covered services:** Payment is due in full. Please be aware that some and perhaps all of the services you receive may be considered a non-covered benefit. You must pay for these services in full at the time of your visit.

**Claims submission:** We will submit your claims as a courtesy to you. **Your insurance company may need you to supply certain information directly.** It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to the contract.

**Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

**Non-payment:** If your account is over 45 days past due, you will receive a letter stating that you have 7 days to pay your account in full. Partial payments will not be accepted. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular mail that you have 30 days to find alternative dental care. During that 30 day period, our dentist will only be able to treat you on an emergency basis.

**Missed appointment:** Our policy is to charge \$100.00 per hour for missed appointments not canceled 48 hours prior to the appointed time. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing **State of the art** dental treatment to our patients.

Thank you for understanding your payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

---

**Signature of patient or responsible party**

**Date**