

[www.drgregweaver.com](http://www.drgregweaver.com)

**Financial Policy**

In order to deliver comprehensive quality dental care for our patients at reasonable fees, it is important to control costs. Since it is unfair to pass the additional costs of carrying and collecting overdue or delinquent accounts of a few to all of our patients in the form of increased fees, we ask each patient to accept financial responsibility for the fees involved in their dental treatment, as we accept the professional responsibility for providing that care.

We trust that you understand and appreciate the need for a clear policy regarding your account. We ask you to please read the financial information and sign at the end. Please feel free to ask any questions of our staff.

You are asked to settle all accounts at the time of service. Special payment arrangements are available upon request if made in advance of the appointment. If you believe there are mistakes concerning your account, please contact us by phone during business hours. If we do not hear from you, we assume everything is correct with your account. For your convenience we accept cash, check, VISA, MasterCard, American Express, Discover and bank financing upon credit approval. Professional services are rendered and charged to the patient and not the Insurance Company, we will always be happy to assist you with your insurance.

All accounts are covered under the following provisions:

1. We ask that you pay us and have your insurance company reimburse you. We will give you an itemized copy of your charges of your charges for the visit.
2. Any accounts remaining unpaid over sixty (60) days will incur finance charges at 1.5% per month and are delinquent.
3. All returned checks are assessed a $25.00 charge. Since your bank must, by law, inform you of a non-sufficient funds check, we expect you to contact us to make arrangements for settling the full amount of the check plus $25.00, within five (5) days. All other policy provisions as noted above apply.
4. Any accounts requiring legal assistance for collecting will have all legal fees, collection and court costs added to unpaid balance.

We thank you for your cooperation and look forward to providing dental care for you and your family with a clear understanding of each party’s responsibilities.

I read and fully understand the above Financial Policy.

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILD’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_