

OAKRIDGE DENTAL CENTER

FINANCIAL POLICY

Thank you for choosing us for your dental care. Our mission is to deliver the finest, most effective health care treatment available today. We pride ourselves on providing optimum dental care...any treatment we recommend for you would also be treatment that we would recommend for one of our own family members. In order to keep our fees as low as possible, your portion of the payment for services is required at the time of treatment. If you need extensive treatment that will require several visits to complete such as crown or bridge work, financial arrangements can be made with you in advance prior to the initiation of your treatment.

IF YOU HAVE DENTAL INSURANCE...

We work with over 400 insurance plans in our office. As a courtesy to our patients, we gladly will submit your insurance for you for the date services are rendered. **Please understand that your insurance policy is a contract between you and your insurance carrier**-we are not party to this contract and our estimate of your balance may not be accurate until we receive payment from the insurance company. Your balance is your responsibility

It is also important for you to know the remaining dental benefits you have for the calendar year and maximize those benefits because they do not carry over to the next benefit year.

PAYMENT OPTION 1. Cash, Check or Credit Card for your portion at the time of service.

PAYMENT OPTION 2. For treatment plans over \$1000 a 10% down payment is required to reserve amount of time needed for scheduled visit. We do participate with a financial plan (Care Credit) that provides one year interest free payments for qualified applicants.

Please remember, it is your responsibility to notify our office of any insurance or employment changes. Failure to provide this information may result in your being responsible for the entire account balance.

Thank you for understanding our financial policies. Please let us know if you have any questions or concerns.

By signing this document, I agree to abide by and uphold the above standards.

Patient/Guardian _____ Date _____

Witness By (Oakridge Representative) _____ Date _____

PLEASE SEE THE BACK FOR OUR CANCELLATION POLICY

OAKRIDGE DENTAL CENTER CANCELLATION POLICY

Respecting your time is very important to us. We book our appointments around your procedure so you are in and out in a timely manner. We try very hard to keep on schedule and pride ourselves on our punctuality. In return, we ask that you keep your scheduled appointment. We need at least 24 hours notice. If we do not have at least 24 hours notice, a cancellation fee of \$35.00 will apply for every missed appointment with the hygienist and \$60.00 will apply for every missed appointment with the dentist.

By signing this document, I agree to abide by and uphold the above standards.

Patient/Guardian: _____ Date _____