3G FAMILY DENTISTRY

Financial Policy

Thank you for choosing 3G Family Dentistry as your dental care provider. Please understand that payment of your bill is considered part of your treatments. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

- **Payment is due in full at the time of service**

- We accept cash, check, VISA, Mastercard, and American Express

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a service to our patients, we are happy to submit an insurance claim for you. Please be aware that insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute of payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. We cannot be held responsible for the amount of payment from your insurance company. **Patients with no insurance will receive a 20% professional courtesy discount on services that are paid in full at the time of service.** This is intended to help ease the burden of dental care for those without insurance.

As the responsible party, I understand that it is my responsibility to know and understand my benefits, and that fees quoted in this office are only estimates. I will be personally responsible for anything the insurance does not cover.

There will be a $20 returned check fee assessed to your account on all returned checks.
There will be a $50 cancellation/no show fee if you are unable to make your appointment without giving at least 24 hours prior notice.

By signing below, I agree to pay all amounts owed within 30 days of when such amounts are incurred. **I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me.** Regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. **I agree that interest will accrue on all past-due amounts at the rate of 18% per annum (1.5% per month) until paid in full. I also agree to pay a $10 statement fee for balances not paid in full at the time of service.** Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency. The terms of this paragraph shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility whether such amounts are incurred today or hereafter.

_____
Print Name

_____
Signature of patient or responsible party Date