edmond
DENTAL CENTER
family and sedation dentistry
Michael L Chandler | DDS, PC

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FINANCIAL POLICY FOR OUR PATIENTS

Our office wants all of our patients to be able to comfortably afford dental care. We proudly offer the following financial policy so that our patients can have the opportunity to decide which payment option best suits their needs.

It is customary to pay for professional services when rendered. We ask that the fee be paid in full at the time of treatment unless other arrangements have been made in advance.

PAYMENT OPTIONS

1. **CASH**
2. **CHECK**
3. **INSURANCE**
4. **THIRD PARTY FINANCING**
5. **MASTERCARD, VISA, DISCOVER**

INSURANCE

Our office understands the value of insurance benefits to our patients and will gladly work with you to help get the maximum benefit available to you. We will ***estimate*** your deductible and the portion that is covered by your insurance carrier. **The amount determined not to be covered by the insurance carrier is due at the time of the treatment** and may be paid by any of the above options. Our ***estimate*** is subject to the final approval by your insurance company and could therefore change the amount due to our office. Any balance will then be billed or credited to you.

We are happy to assist you with your dental insurance and will file your claim for you. However, we ask that you read your policy to be fully aware of any limitations of the benefits provided. With thousands of insurance companies available today, we will help you in any possible way, ***but it is your responsibility to know the limitations of your policy.*** **You are responsible for payment in full if for any reason your insurance company does not pay what is expected.**

By signing below, you agree that you have read and understand the above information and accept the financial policies of this office. You also agree to allow us to file your insurance claims for you and accept assignment of benefits. Any balance owed after 90 days will be turned over to an outside collection agency for resolution.

Signature of Patient/Parent _____Date_____