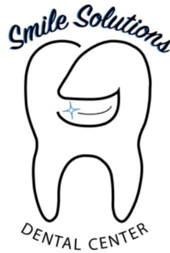

Financial Policy

Thank you for choosing Smile Solutions Dental Center as your dental care provider! We are committed to you treatment being successful.

All patients must complete our Registration forms as well as our Medical and Dental History forms before seeing a dentist.

Full payment is due at time of service. Our fees are not negotiable.
We accept cash, checks, or most major credit cards.
We are happy to discuss financial arrangements prior to treatment.

Regarding Insurance

- We may accept assignment of insurance benefits AFTER your initial visit. You are expected to your share at time of service: (1) deductible, (2) 20% of basic work, (3) 50% of major work. The balance is your responsibility whether your insurance pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the service provided may be non-covered services and not considered reasonable by your insurance policy.
- Regarding Self-Insured Dental Plans (administered but not paid by an insurance company): All payments are due at the time of treatment. All charges for the patient are due 30 days after treatment if Self-Insured has not paid.
- Regarding Insurance Plans where we are a participating provider (HMO & PPO type): All co-pays and deductibles are due at time of treatment. A finance charge will be added for all overdue balances.

Usual and Customary Rates

- Our fees are usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

- The adult accompanying a minor, whether be the parents or the guardian of the minor, are responsible for full payment.

Missed Appointments:

- All appointments must be cancelled at least 24 hours in advance. Our policy is to charge $50 for any missed appointments.

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

I have read the Financial Policy. I understand and agree to this policy.

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Signature of Patient or Responsible Party   Date