Thank you for choosing our practice. Payment or co-payment is due at the time services are rendered unless prior written financial arrangements have been made.
We accept:

- Cash, Credit/Debit Cards, HSA/FSA Cards, BDG Discount Plan, Third-party financing (if approved)

Self-Pay
As a courtesy, we do offer a percentage discount for patients without dental insurance benefits or third-party financing. Please speak to our front desk with any questions.

Insurance & Assignment of Benefits
As a courtesy, we will submit claims to your dental insurance carrier.

- Your insurance policy is a contract between you and your insurance company
- In most cases, reimbursements are based on the plan your employer chose
- Any estimate we provide is **not a guarantee of payment**

By signing this policy, you:

- Authorize assignment of benefits directly to our office (if applicable)
- Authorize release of necessary information to process claims in compliance with **HIPAA**

You are responsible for:

- Deductibles, Co-payments, Non-covered services, and any balance remaining after insurance payment

If your insurance has not paid within **90 days**, the balance becomes your responsibility.

Non-Covered Services & Waiver
Certain procedures may not be covered by your insurance plan.

- You agree to pay for all services rendered, regardless of insurance coverage determination

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Late Payments & Collections
Accounts over **90 days past due** may be subject to a billing fee, monthly finance charge, and an annual percentage rate in accordance with Ohio law.
In accordance with Ohio law, delinquent accounts may be referred to a collection agency or attorney.

Consent for Treatment & Financial Responsibility
You have the right to accept or refuse treatment after being informed of the risks, benefits, and costs.
By signing below, you:

- Acknowledge understanding of this financial policy
- Accept full financial responsibility for services provided
- Agree to pay all charges not covered by insurance

Acknowledgment & Agreement
I have read, understand, and agree to the terms of this Financial Policy.

Patient Name: ______________________________

Signature: ______________________________

Date: ____________________

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