HIGLEY GROVES DENTAL, PC
Financial Policy

- **I understand that all responsibility for payment for dental services provided in this office for myself or dependents of myself is mine, due and payable at the time services are rendered unless other arrangements have been made.**

- **I understand that my insurance coverage is a contract between my employer and the insurance company. Not all services are a covered benefit. Some insurance companies arbitrarily select certain procedures they will not cover. We must emphasize that as a dental care provider, our relationship is with you, and not your insurance company. Filing your insurance claim is a courtesy we extend to all of our patients. We can make no guarantee of any estimated coverage or payment.**

- **We offer many forms of payment. All major credit cards are accepted. We also offer no-interest, same as cash financing through CareCedit.**

- **I understand in the event that my account would need to be assigned to an outside collection agency, a collection fee of 35% of the balance may be added to my account.**

- **I understand that my appointment has been reserved especially for me, and in the event that I need to reschedule, I will give a 24-business hour notice. Failure to do so may result in a cancellation fee.**

- **I understand that it is my responsibility to advise this office of any changes in the information I provide regarding my insurance, patient information, or health history.**

- **I understand that fees may be applicable for dental records and/or copies of dental x-rays.**

- **I understand that there will be a $25.00 insufficient funds fee added to my account in the event of a returned check.**

Patient Signature: ___________________________________ Date: ______________

Parent or Responsible Party: _________________________ Relationship: _________