NORTH POINT
DENTAL GROUP, LLC

# Financial Policy

Thank you for choosing North Point Dental Group, LLC. We would like to welcome you to our practice. Our mission is to deliver the best dental care available, and our goal is to make the cost of optimal care as easy and manageable as possible to all our patients.

- **Payment is due at the time of service.** For your convenience, we accept cash, personal check, Visa, MasterCard, American Express, Discover, cashier's check, and CareCredit®.
- Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you and your insurance company. **Insurance is not a guarantee of payment and your benefit may not match your individual treatment needs.**
- As a courtesy to you, we will file a claim on your behalf with your insurance company. Every reasonable effort will be made to verify your insurance benefit and accurately estimate both your benefit and the portion of payment for which you will be responsible. **Any deductible and/or estimated co-payment will be due at the time of service.**
- If we are unable to verify your insurance benefits, you will be expected to pay for the services rendered.
- If your insurance company has not paid your claim within **45 days**, **the remaining balance is your responsibility** and is considered due and collectible at that time.
- It is your responsibility to inform North Point Dental Group, LLC of any changes to your address, phone number, or dental insurance policy so that your coverage can be verified prior to your appointment.
- A **returned check fee** of $35 will be added to your account balance.
- A service charge may be charged on all balances not paid within 60 days.
- We reserve the right to charge a fee for broken appointments – appointments that are missed or canceled **without 2 business days' notice. A fee of $50 will be incurred for a broken continuing care appt with a hygienist. A fee of $50 per ½ hour of time reserved will be assessed for broken appointments with a doctor.**

I have read and understand this financial policy.

_______________________________________________      ____________________
Signature of Patient or Guardian      Date

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Printed Name of Patient or Guardian