FINANCIAL POLICY

1. Payment is due at the time of service. We reserve the right to apply a $15.00 service charge if a statement needs to be prepared.

2. We do accept Cash, Check, Visa, MasterCard, American Express, Discover, Care Credit.

3. Returned checks are subject to a $30.00 service charge and may terminate your privilege to pay by check in the future.

4. IN THE EVENT OF A MISSED OR CHANGED APPOINTMENT WITH LESS THAN 48 HOURS NOTICE, WE WILL REQUIRE A NON-REFUNDABLE DEPOSIT TO RESERVE ANOTHER APPOINTMENT. The deposit for hygiene appointments will be $75.00, deposit for appointments scheduled with the doctor will be 1/3 the total cost of the services scheduled. The deposit will be applied to services received at scheduled appointment. If 2ND appointment is missed or changed with LESS than 48 hours, the deposit is lost. Many times our patients require urgent or emergency treatment and require an appointment as soon as possible. When patients give the office advanced notice of their need to change an appointment this time can be allocated to those patients in urgent need of treatment. This allows our office to best serve the needs of all our patients.

5. It is understood and agreed that in the event any outstanding balance has to be referred to a collection agency or an attorney for recovery, that you will be fully responsible for all collection agency and attorney fees.

DENTAL INSURANCE

Our office accepts most dental insurances and is happy to prepare all claims for you. Dental insurances are designed to be a financial assistance, not payment in full. Each plan has their own set of guidelines and limitations. Please refer to your “book of benefits” so you can be knowledgeable of your plan. We will do everything within our power to help you utilize and maximize your insurance benefits. Unless prior arrangements have been made, we do not accept assignment of benefits. The insurance company will pay dental benefits directly to the insured. It is the financial responsibility of the patient for any and all fees associated with services provided by White Spruce Dental.

PLEASE SIGN BELOW TO INDICATE THAT YOU HAVE READ AND FULLY UNDERSTAND OUR OFFICE POLICY AND AGREE TO THE TERMS AND CONDITIONS REFERENCED THEREIN, WHERE APPROPRIATE CREDIT BUREAU REPORTS MAY BE OBTAINED.

Signature_____________________________ Date________________

Kenneth D. Nozik, D.D.S.
John M. Tumminelli, D.D.S.