FROST
PERIODONTICS & DENTAL IMPLANTS

Financial, Insurance & Appointment Policies

Financial Policy

- $25 will be collected upfront at each visit
- We accept cash, checks, Care Credit ®, and all major credit cards (except American Express).
- There is a $25 fee for returned checks.

Insurance Policy

- We understand that you may have dental insurance. As with most specialty providers, we are out of network. Our treatment plan is based on your needs as a patient and not according to your insurance coverage.
- We will gladly file your insurance claim when treatment is rendered.
- For patients with Delta Dental & BCBS: We typically do not receive any claims communication from these companies. Therefore, payment in full is expected for all appointments & procedures

Treatment Appointments

- To allow expedient care for our patients, 50% down payment is required for all procedures.
    - For downpayments made by credit card, 5% is non-refundable.
- The remaining 50% balance will be divided into 2 equal monthly payments. These payments will be automatically charged to a card on file (debit or credit) the first of each month after insurance payment for your procedure is received.
- For patients paying with Care Credit ®, the procedure fee will be paid in full to schedule.
    - The monthly payments will then be made directly to Care Credit ®

New Patients, Maintenance Patients

- Once your insurance claim has processed and we receive the EOB, **the remaining patient balance will be automatically charged to the debit or credit card on file.**

Appointment Cancellation Policy

- All procedure appointments require 7 days-notice for cancellation or rescheduling.
    - If less than 7-day notice is given, a fee of $50 will be charged.
- A $50 fee will be charged for late cancellation under 48 hours for any appointment.

Late Patient, No Show Policy

- Patients who arrive more than 15 minutes late to their appointment may be asked to reschedule as a courtesy to our other scheduled patients.
- A $50 fee will be charged for those who fail to show to a scheduled appointment.

To acknowledge that you have read and understood our policies, please print and sign below.

Patient Acknowledgement_____ Date _____

Office Administration Signature _____ Date _____