Divine Dentistry, LLC
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Our Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service. We accept Visa, MasterCard, Discover, Care Credit, and Debit Cards. Debit and Credit Cards are charged a 3.5% service fee at the point of sale

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we fill file your insurance claim if you assign the benefits to the doctor. If your insurance company does not pay the practice within a reasonable period, the payment for the services received from will be your responsibility. If we later receive payment from your insurance company, we will refund any overpayment that has been paid by you to you.

3. We have made prior arrangements with many insurance companies and other dental plans to accept an assignment of benefits. We will bill them and you are required to satisfy your deductible, and coinsurance at the time of your visit.

4. If we do not participate with your insurance plan, as a courtesy we will file your claim for out-of-network benefits. You will be responsible for your portion of the charges at the time of service. You are responsible for finding out whether we participate in your insurance company's network.

5. Not all insurance plans cover all services. In the event your insurance plan determines a service that you chose to receive to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

6. We will bill your insurance company for all services provided. You are responsible for any balance due.

7. It is the policy of Divine Dentistry, LLC: if you NO-SHOW for a confirmed appointment, you will be charged a ***$75.00 NO-SHOW fee*** to be paid before your next visit. The NO-SHOW fee is your responsibility and will not be billed to your insurance plan. If you should need to cancel or reschedule an appointment, please give at least 2 to 3 days advanced notice to avoid any NO-SHOW fees and to be eligible for future appointments. If you are 15 minutes late to your appointment, you may be rescheduled. If you did not confirm your appointment, your appointment may be given away.

8. If you require additional treatment on a day other than the FREE EMERGENCY DENTAL DAYS, YOU ARE RESPONSIBLE FOR PAYMENT.

9. If you decide to pay ahead on your account in order to help offset payment due at time of service, understand that this is a NO-REFUND POLICY. The credit balance must be used or transferred to another patient of record within 6 months of initial payment made. There must be activity of use or payment every 30 days or less.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

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Signature of patient (or responsible party if minor) ***Date***

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Printed name of patient (or responsible party if minor) ***Date***