Financial Policy

This statement is to inform you of our financial policy. Here at SpringHill Dental, caring for and being conscious of our patient's financial and dental needs is a priority of ours. Dental treatment is an excellent investment in a person's medical and psychological well-being, financial considerations should not be an obstacle in obtaining this important health service. We work with all major insurance companies to get you the most benefits possible, and offer interest-free, low monthly payments through Care Credit.

Payments are due the day a service is provided, unless other arrangements have been made prior to your treatment date. Our office accepts cash, checks, all major credit cards, and Care Credit.

As a courtesy, our office will file all dental insurance claims on your behalf. In order for our office to file your insurance claims, you must provide us with all the accurate information prior to your appointment, if we are unable to verify your insurance coverage you will be required to pay the entire balance. You are responsible to make our office aware of any changes to your insurance. All deductibles and patient portions are due the day a service is provided.

All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage. As your dental care provider our relationship is with you and not *your* dental insurance. Your dental insurance is a written contract between you, your employer, and your dental insurance company. Our office is not a party in that contract or any possible restrictions. We recommend checking with your dental insurance prior to treatment.

Returned checks are subject to a $25.00 fee. All accounts not paid within 30 days after a statement is processed will be subject to a $25.00 per month late charge. **PATIENTS WHO FAIL TO SHOW UP FOR THEIR APPOINTMENT WITHOUT 24 HOUR ADVANCE NOTICE WILL BE CHARGED A NO SHOW FEE OF $35 PER HOUR OF APPOINTMENT SCHEDULED. For example, if you schedule a 1.5 hour (90 min) appointment, your fee would be $35 x 1.5 hour = $52.50.**

If you have any questions regarding our financial policy please do not hesitate to ask.

_____ _____

Patient or Guardian Signature Date