

Steven M. Van Scoyoc, D.D.S., M.S., P.A.

Practice Limited to Periodontics & Implants

FINANCIAL GUIDELINES

Thank you for choosing Dr. Van Scoyoc as your periodontal healthcare provider. Our office is committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. **Payment is expected in FULL at the time of service.** We accept cash, check, Visa, MasterCard, Discover and Care Credit. If you are eligible, Care Credit offers six and twelve month no-interest payment plans. You can apply in our office, online, or over the phone and you can begin your treatment the same day. Please ask our staff if you are interested or have any questions.

There will be a \$25.00 handling charge for any returned checks.

In order for our office to serve you better, there will be a \$50.00 charge for missed exams/cleanings and a \$100.00 charge for missed surgical appointments. You must cancel your appointment at least **twenty-four hours in advance**, or it will be treated as a missed appointment.

Insurance Policy:

Our staff will work very hard to ensure your claim is filed accurately and promptly in order to assist you in receiving the maximum dental benefits that your plan allows. Regardless of insurance coverage, the total fee is your responsibility at the time of service.

Our office will be glad to mail your primary claim to the insurance company for you. The insurance company will then **reimburse you** for the procedures that were covered. Our office does NOT guarantee payment by your insurance company. In addition, we are unable to enter into a dispute with your insurance company over your claim. We will aid you in any way possible to get your claim paid. If you have an outstanding balance with us, and the insurance company pays you directly, it is your obligation to send us a check for your dental services immediately upon receipt of the insurance check. **It is also your responsibility to inform our office of any changes in your dental coverage prior to your appointment.**

I HAVE READ, UNDERSTAND AND AGREE TO THE FINANCIAL POLICY STATED ABOVE.

Patient's Signature

Date