Colonial Heights Dental Group

Susan Burks Creech, DDS

Financial and Insurance Guidelines

For the convenience of our patients, the following office policy and financial agreement has been established for your review.

INSURANCE: Your dental benefits are based upon a contract made between you or your employer and an insurance company. **Depending on your dental needs, dental insurance benefit plans may not cover 100% of your dental care. If you have any questions regarding your dental insurance benefits please contact your employer or insurance company directly.**

We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**.

We require payment of your **estimated** portion at the time of treatment. We will bill your insurance to maximize your benefit. It may take several weeks to receive payment from your insurance company. Once final payment has been received a statement of the remaining balance, if any, will be sent to you. We request that payment be made in a timely manner to avoid late fees or collection activity. You are ultimately responsible for what your insurance will not provide: deductible, co-insurance, and non-covered expenses.

EXCEPTION: Cosmetic dentistry is not a covered expense through dental benefits! Due to the specialty lab costs and time allowed for cosmetic treatment, you are responsible for payment at time of service, and pre-payment may be required to reserve an appointment time.

PAYMENT POLICIES: We accept Cash, Check, Visa, MasterCard, Discover, and American Express. We also accept CareCredit as payment. If approved CareCredit offers 6 months no interest financing on services over $400. An application for CareCredit approval can be submitted in office and will have a response within just a few minutes.

I, _____, understand and agree to the appointment and payment policies for Colonial Heights Dental Group. I authorize release of my dental/medical histories and other information about my dental treatment to third party payers.

_____ _____

Signature (Patient or Responsible Party) *Date*

_____ _____

Office Representative *Date*