PAYMENT POLICY

Patient Name: _____

Our first priority is to provide you with quality dental care. In order to consistently do so, we must request that payment be received at the time services are rendered. We do accept several payment options for your convenience.

Cash
Checks
Visa/Mastercard/Discover/Novus/American Express
Care Credit Patient Financing

There is a $15 fee for ***all*** returned checks

Insurance:

We accept assignment of insurance benefits as a courtesy to our patients. The patient is always responsible for the bill in the case of a conflict with the insurance company. The patient is responsible for updating insurance information with our office when there are any changes. You should always be aware of what your own coverage entails.

Patient must pay ***their portion*** of the bill ***in full*** as services are rendered.

Financing:

There will be no financing directly from our office. You may apply for a Care Credit account if you wish to make monthly payments on your balance.

Second Opinion and Consultation:

There is an office visit charge which will include the fee for consultation and any necessary x-rays.

Missed Appointments:

There will be a $50 fee for appointments missed or cancelled without 2 Business days notice. We understand that sometimes there are legitimate reasons for missing appointments and we will take this into consideration when enforcing this policy.

I have read the above and understand the payment policy of Dr. Hal Hirsch

_____

Patient Signature (Parent if a minor) Date