Apple Valley Dental Group
Financial Policy

Thank you for choosing our practice as your dental provider. We are committed to providing you with the highest quality of care. Please review the following expectations and indicate your willingness to accept responsibility by signing this form below.

- Estimated insurance co-payments are due at the time of service. You will be given your estimated co-pay in advance of your next appointment.

- If you are uninsured, we require payment in full at each visit. We offer care credit, accept cash, checks, visa/mastercard and discover.

- We will ask that you update you individual information at each visit, so that we can ensure correct and timely billing. After payment is received from your insurance company, any outstanding balance will be transferred to your personal responsibility, at that time you will be asked to settle your account.

- Failure to pay your bill in a timely manner will result in our practice forwarding your account to a collection agency. Should we proceed with collections, you will be responsible for any costs charged to us by our collection agent. In addition, we will schedule no future appointments until you have settled any outstanding balance.

- We require that you give our office a 24 hour appointment cancellation notice. A $36 Fee will be charged to your account for less than 24 hrs notice or for failure to keep your scheduled appointment without any notification.

I have read this Financial Policy and agree to these terms.

_____ _____

Patients Signature **Date**

_____

Print Name

_____ _____

Guardian Signature **Date**