FINANCIAL POLICY
FOR THE OFFICE OF THOMAS M. REEDAL D.M.D.

We are excited to welcome you to our office. New patients are always appreciated. Our practice has grown as a result of its excellent relationship with our referring doctors and patients. Please feel free, at anytime, to express any concerns or questions that you may have about treatment or our fees.

In the interest of good health care, it is desirable for us to establish a financial policy to avoid misunderstandings. Our primary responsibility is to help our patients achieve good oral health and we want that to be our main focus.

IF YOU DO NOT HAVE INSURANCE: Payment is due in full at the time treatment is provided, unless other arrangements have been made with office administrator.

PAYMENT: You may make any payment using cash, check, Master card or Visa.

IF YOU HAVE INSURANCE: Services are performed and charged to the patient not to the insurance company. As a courtesy to you, we will send your insurance claims in. You must provide us with current information and necessary forms. You are responsible, at the time of your appointment for any deductible or co-payment not covered by the insurance company. If the exact amount covered by insurance cannot be determined at the time of your appointment, we request that you pay your deductible if applicable. Even though you may have an insurance claim pending, you will receive a monthly statement for the outstanding balance on your account. If there is a payment credit, a check will be issued to you.

INSURANCE PATIENTS PLEASE READ CAREFULLY: The amount of coverage paid by your insurance company may be based on your insurance companies own reduced fee schedule for treatment and may be **less than actual charges** resulting in lower coverage for you. We have **no control** over this situation. **Lower payment is a direct result of the plan selected by your employer.**

We require at least 24 HOURS NOTICE on all appointment cancellations. We understand that emergencies do occur. However, excessive cancellations may result in a cancellation charge of $30.00. We may also exercise our right to refuse further services. Our time must be used as efficiently as possible in order to provide quality care to all our patients.

I have read the office policy and understand that regardless of any insurance coverage I may have, I am responsible for payments on my account. I understand that delinquent accounts may be assigned to a collection agency.

Signature_____ _____**Date**_____