Marquis Family and Sedation Dentistry

Dear Valued Patient:

Thank you for choosing us as your dental care provider! Our main concern is that you receive the proper quality treatment. In order to prevent misunderstandings and to serve you better, we ask you to read our financial policy. If you have any questions please do not hesitate to contact our office.

Full Payment for services is due at the time of the treatment. We accept CASH, MASTERCARD, VISA, DISCOVER and DEBIT. We do **not** accept American Express or personal checks.

1. We will file your insurance if you are a member of an insurance plan with which we are in network. We will make every attempt to verify your coverage. Fixed co-pays, deductibles, and non-covered services will be collected at time of treatment.

2. **Unless cancelled at least 48 hours in advance, our policy is to charge for all missed and/or no-show appointments. Missed and/or No-show appointments are subject to a $50.00 per hour and per each missed appointment charge. This charge is not covered by your insurance.**

Accounts turned over for collections

Should your account be turned over for collection, you agree to pay collection agency fees of 30% of your principal balance. If the account is referred for litigation, additional attorney's fees of 50% of the principal balance will be assessed.

The collection agency that we use does report bad credit to the three national credit bureaus. You may also be given notice legally dismissing you from our practice and asked to find another dental provider.

We understand that temporary financial problems may affect your timely payments of your balance. We encourage you to communicate such problems with our office so that your account can be properly managed. THANK YOU for choosing us as your health provider. We appreciate your trust in us and we look forward to serving you.

By signing below, I acknowledge that I have read Marquis Family Dentistry's financial policy and agree with the terms set out in this policy. I am aware that my dental insurance may not reimburse for my dental treatment and that ***I am responsible for my account.***

Patient signature/date