

Financial Policy

GENERAL

Thank you for choosing Southern Oregon Periodontics as your dental specialist. We are committed to providing you with the highest quality service and treatment. In order to do so, we expect payment in full when services are rendered. We do, however, offer some flexibility for your convenience. The following is a statement of our Financial Policy, which we require you to read, and sign prior to treatment.

TREATMENT PLANS

Fees are estimates only, are valid for 30 days from the date presented, and are subject to revision. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment.

CASH & CHECKS

At time of service, we will gladly extend a 5% courtesy adjustment when you pay in full. Your previous account balance must be zero to receive the courtesy adjustment. Returned checks are subject to a fee of \$25.00 (for each check).

VISA, MASTERCARD, DISCOVER, & AMERICAN EXPRESS

We gladly accept these major credit cards, but ask that you present them in person.

FINANCING

For your convenience, we offer both Care Credit & Chase Health Advance healthcare financing. You may be able to qualify for a comfortable monthly payment plan. Let us know if you are interested in this option.

REGARDING INSURANCE

As a courtesy to our patients, we will gladly assist you in insurance submission. Typically, reimbursement will be paid directly to you. Our fees are set thoughtfully and with flexibility. Realize, though, that these fees may still be more than what is considered usual and customary. It is our custom to provide exceptional service. If you require a more accurate estimate, you may request a predetermination to be filed.

MISSED APPOINTMENTS

Unless canceled at least 48 hours in advance, our policy is to charge \$50.00 for broken appointments. Extenuating circumstances will be given consideration, but repeated instances will not. Please help us serve you better by keeping scheduled appointments.

INTEREST & COLLECTIONS

We reserve the right to charge interest in the amount of 18% per annum as provided by state law. In the event that your account is not paid and we refer the account to collections, you will be responsible for all fees incurred for collection of your bill.

CONSENT

I understand and agree to this Financial Policy.

Patient/Guardian Signature

Date