Patient Financial Policy

petriedental@gmail.com

We at Petrie Advanced Dental are here to help you achieve excellent oral health in the best possible way. Our practice is dedicated to quality care and exceptional service. We respect the importance of your time and we work very hard to schedule appointments that accommodate the busy scheduling needs of our patients.

Office Policy:
We value your time and ask that you value ours by arriving on time for all appointments.

Please silence your cell phone during your dental visit.

We ask for a minimum of 48 hour notice to cancel or reschedule your dental appointment. You may be subject to a $25.00 charge for per half hour. If there is more then (3) missed or broken appointments within a reasonable amount of time you may be unable to pre-appoint. _____initial

Financial Obligation:
You are responsible for the total payment of all procedures performed in this office. As a courtesy we will bill your insurance for you and you will be responsible for the estimated portion at the time of service, unless prior arrangements have been approved. _____initial

We accept the following forms of payment:

- Visa, MasterCard, Discover, American Express
- Care Credit
- Checks
- Cash

Please make your questions and concerns known to our accounts manager who is happy to discuss this policy and ensure that you have an outstanding experience.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. I understand that all treatment plans and estimates are subject to change and are provided as a courtesy to me. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to my account. However, this dental office cannot render services on the assumption that my charges will be paid by an insurance company.

A service charge of 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, byh the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suite be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature (responsible party) Date

Email Address