



THE CASTLEBERRY CENTER  
FOR AESTHETIC DENTISTRY

## Financial Policy

We value you as a patient and are committed to providing you with the best possible dental care. We want you to have a complete understanding of your financial responsibilities for the services to be provided. To assist us in achieving these goals, we ask that you review our financial policy.

Unless our authorized staff has approved payment arrangements in advance, payment in full will be due at the time services are rendered. We will be happy to help process your claim for reimbursement or you may assign your primary insurance benefits to the doctor as a partial payment toward the services rendered. This can be done after we have had the opportunity to verify your primary insurance benefits. At the time of your appointment, you will be expected to pay your deductible as well as any portion of the treatment fees that we estimate will not be covered by your insurance policy. Because of insurance policy changes and/or necessary changes in treatment plans, your dental coverage may vary from this estimated treatment calculation or your carrier's pre-estimate. **If your insurance company has not paid the full balance of the claim within 60 days from treatment date, you will be responsible for paying the outstanding balance immediately.**  
**NO EXCEPTIONS**

Please remember that your insurance is a contract between you and your insurance company and/or employer. Our dental practice is not a party to that contract. **It is your responsibility to verify the amount of insurance coverage for the specific treatment with your insurance's company, as well as to verify that this office has the correct insurance information, including plan information.**

A finance charge of 1.5% per month may be assessed to accounts with balances outstanding for 60 days from treatment date. The FINANCE CHARGE represents ANNUAL % RATE of 18%.

If your check is dishonored or returned for any reason you expressly authorize our office to electronically debit your bank account for the amount of the check, plus a \$45.00 processing fee. Your use of a check for payment is your acceptance of the agreement and its terms.

All treatment charges are the responsibility of the patient or responsible party regardless of insurance coverage. In the event of non-payment, the patient agrees to pay all the costs of collection including but not limited to attorney fees, court costs, collection agency fees, etc.

No charge will be made for rescheduling an appointment provided 24 hours notice is given. Otherwise, a minimum charge of \$50.00 (per ½ hour missed) will be charged. Once an appointment has been made, please remember this time has been specifically reserved for you. ***I have read and understand the financial policy of this practice and I agree to the bounds of its terms. I also understand and agree that such terms may be amended from time to time by the practice.***

***Signature of Patient/Parent/Guardian\_\_\_\_\_ Date\_\_\_\_\_***