BELMONT DENTAL GROUP
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FINANCIAL AND APPOINTMENT POLICY

INSURANCE

There are many dental insurances available, but no matter what insurance you have we will submit your treatment to that insurance. If you provide Belmont Dental Group with insurance information please make sure the information is accurate and up to date. Any discrepancy in providing this information could result in incorrect or late submissions to your insurance and a possible lapse in coverage, for which Belmont Dental Group is not responsible.

It is your responsibility to read and understand your insurance policy including benefits, limitations and exclusions. If you have any questions when you are in our office, our insurance team will do their best to answer them. Be advised that any agreement on coverage is between the insurance company and the subscriber and not the responsibility of Belmont Dental Group. [_____] initial here Any remaining balance from cleanings or other treatment that your insurance does not cover will be your responsibility to take care of. Payment for services are due at the time of your appointment unless other payment arrangements have been made with the financial department. A ***finance charge*** of **1.5%** per month will accrue on any balances unpaid after **30 days** from the date of treatment.

APPOINTMENTS

If you need to cancel or reschedule an appointment, please do so with at least a 24-hour notice. This allows you time to reschedule the appointment in a timely manner to better suit your schedule, and gives Belmont Dental Group time to refill that appointment time. For any appointment not rescheduled or cancelled within this 24-hour window, we reserve the right to charge a fee of $55 for our time.

We understand that sometimes emergencies cannot be prevented and at times 24-hour notice may not be possible, but please respect our need to serve you can other patients as well and adjust your appointment times as soon as you are aware that it is necessary.

By signing this form I agree that I have understood the above outlined policies at Belmont Dental Group. I give my permission to Belmont Dental Group to bill my insurance for the treatment provided, if applicable. If I do not have dental insurance, it is my responsibility to pay at the time of service, unless other options have been agreed upon in writing with me and Belmont Dental Group. I agree that the status of my account with Belmont Dental Group is within my control. If I am unable to keep my account current after repeated notices, I understand that my account may be taken to collections.

Patient Name (print): _____

Patient/Responsible Party Signature: _____ Date: _____