FINANCIAL POLICY
Dr. Chris Maffett

Thank you for choosing our office for your dental needs. To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

PAYMENTS
Payments are expected at the time services are rendered. We accept cash, checks, debit cards, Visa, MC, AMEX and Discover.

By arrangement with CARE CREDIT, we offer our patients, upon credit approval, an interest-free loan (up to 6 months) with no down payment, no annual fee, and no prepayment penalty. Please ask for an application.

INSURANCE
As a courtesy, our office will file your dental insurance for you. We will estimate what your insurance will pay and collect your portion or co-pay at each visit. We will do our best to give you an accurate estimate but please remember that it is just an ESTIMATE. All charges are the patient's responsibility regardless of any difference in our estimates and what the insurance actually pays.

Our trained staff will gladly assist you in understanding your dental plan. Upon request, we will submit pre-treatment estimates to your insurance company for their pre-approval. This often takes several weeks and may not be possible for all treatment.

BROKEN APPOINTMENTS
To help our patients manage their busy schedules, we mail post-cards, send e-mails, and make phone calls to remind patients of upcoming appointments. We understand that sometimes things come up unexpectedly and appointments will have to be cancelled at the last minute. When possible please give us at least 48 hours notice of any appointment changes or cancellations. Excessive cancelled or missed appointments will be charged a $75 cancellation fee and may result in dismissal from the practice.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read Dr. Maffett's Financial Policy. I understand and agree to the terms of this policy.

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Signature of Patient or Responsible Party Date

I hereby authorize the release of all information from my records to insurance companies

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Signature of Patient or Responsible Party Date

I hereby authorize payment of all dental payments payable to me to go directly to the provider

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Signature of Patient or Responsible Party Date