Terms of Payment

At Palmetto Dental Associates, we are committed to providing our patients with the best care possible and encourage you to take an active roll in your treatment. In order to keep the lines of communication open, we ask that you review our financial policies stated below. Our team members are always available to answer any questions regarding insurance or other financial matters.

Terms of Payment

For patients with no dental insurance, payment is due at the time services are rendered. VISA, MasterCard, American Express, Discover, Cash, and personal check (no post-dated checks) are acceptable forms of payment. We will make arrangements for large scale treatment, but these arrangements must be made prior to treatment being performed. For your convenience we also offer Care Credit and Lending Club Financing Plans.

Insurance

Patients who have dental insurance, must provide a current copy of their insurance card in order for claims to be submitted properly. We are not a preferred provider for any insurance; however, we will file claims (excluding medicare or medicaid) as a courtesy. It is the sole responsibility of the patient to cover whatever insurance does not pay, and the remaining balance must be paid the day that services are rendered.

Failed Appointment Policy

In order to allow the best possible care for our patients, we ask that you give our office twenty-four hours notice for any changes or cancellations with your appointment. This allows us the opportunity to give that appointment to another patient in need. A fee of $25.00 per appointment hour will incur without twenty-four hours notice.

Authorization

By signing below, you are confirming that you are ultimately financially responsible for services rendered by Palmetto Dental Associates. As stated above, all fees are due at the time of service. In the event that your account become delinquent and is therefore turned over to a collection agency to obtain payment, you understand that you are responsible for any fees levied by the collection agency. A copy of your signature shall have the same force and affect as the original.

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Patient Signature (or Guarantor) **Date**

Acknowledge of receipt of Notice of Privacy Practices (HIPPA)

You may refuse to sign this acknowledgement

I, ______________________________ (print name), have received a copy of this office's notice of privacy practices via the office's website. If desired, I also have the opportunity to review a hard copy of the document at my appointment.

____ ______________________

Patient Signature (or Guarantor) **Date**