Bowers and Oki Family Dentistry, PC

Office and Financial Policy

Thank you for choosing our office as your dental health care provider. This notice is meant to inform you of our office appointment and financial policies.

Payment is due at the time service is provided, unless other arrangement have been made. We accept cash, personal checks, money orders, and most major credit cards. Financing is also available through Care Credit.

All charges you incur are your responsibility regardless of insurance coverage. As your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. As a courtesy to you we will help you process all your insurance claims. In order for our office to file your insurance claim, you must bring a photo ID and proof of insurance to each visit. Your estimated co-payment and deductible for treatment is due at the time service is provided. Insurance companies have various rules and limitations and as such we can only provide you with a coverage estimate. If payment from your insurance company is not received within 60 days from date of service, the unpaid balance becomes your responsibility.

There will be a $35 fee on all returned checks. Balances older than 90 days are subject to collection fees and finance charges at the rate of 1.5% per month. (18% annually). If your account is not paid within 120 days and no financial arrangements have been made, your account may be referred to a collection agency. You will be responsible for all fees and interest charges incurred in collecting on your account.

Your appointment time is reserved for you. If you are going to be late for your appointment, please call our office to see if your late arrival can be accommodated or if we need to reschedule you. Our office has a 24-hour cancellation policy. We do understand that unforeseen circumstances arise. You may be charged a fee for appointments that you do not keep and for appointments that you do not cancel with 24 hours advanced notice.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the most positive experience in dental care.

I have read, understand and agree to the above office and financial policy.

Patient Name: _____

Parent/Guardian Name: _____

Signature: _____ Date: _____