Financial Policy

Welcome! Thank you for choosing Flex Dental. Our primary mission is to deliver the best and most comprehensive dental care available to you and your family. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment

We offer several payment options for your convenience:

- We accept Cash, Checks, Visa, Mastercard, Discover, and American Express
- We offer convenient **no interest** monthly payment options from Care Credit.

Insurance

Our office is committed to helping patients maximize their benefits. We are always available to answer your questions. Nevertheless, your insurance policy is a contract between you and your insurance company. As a dental provider, we are not a part of that agreement, and it is your responsibility to understand your insurance coverage. **Your patient portion, including and deductibles, must be paid at the time of service.** As a courtesy, we are happy to submit to and work with your carrier to maximize your benefit.

Any insurance information is strictly an estimate. We will attempt to verify eligibility before your appointment, but this is not a guarantee of payment from your insurance company.

Missed Appointments

We value your time, as well as ours. Therefore, there is a fee of **$50 fee** for patients who cancel without a 24-hour notice.

Financial Consent

The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office. In addition to the principal amount owed, I also agree to pay 25% of the unpaid balance if my account is turned over to a collection agency or attorney in an effect to collect any outstanding balance. This may include, but is not limited to, filing fees, court costs, collection agency fees, and attorney fees. I understand and agree to this Financial Policy and Agreement. Furthermore, I authorize release of any information relating to any claim or any insurance information. I understand that I am responsible for all dental treatment not covered by my insurance.

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Printed name of Patient/ Responsible Party

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Signed name of Patient/ Responsible Party Date