Dale F. Burke, DDS & Mark G. Williams, DDS

Office Policy Regarding Financial Arrangements

Each patient will be given an estimated cost for the dental treatment before work is started. It must be pointed out that, occasionally, unforeseen circumstances may necessitate additional treatment. If additional treatment is necessary, the patient will always be informed as to its nature and the cost before proceeding.

Payment is expected as services are rendered. Cash, Check, Credit/Debit Cards are acceptable methods of payment. As a courtesy to our patients, we will file an insurance claim for you. Please note that our relationship, as your dental provider, is with you and not your insurance company. *It is the patient's responsibility to check on the status of your claim. Please become familiar with your dental insurance benefits policy*. Some services may **not** be covered. This office is not aware of procedure and diagnosis codes **not** covered by each insurance company. To ask us to change or correct a procedure code, diagnosis code, or date of service is asking your dentist to break the law. This puts your dentist at risk for fraud and abuse charges. We do not want to put you in a position to violate your dental insurance contract.

We Offer the following Payment Methods:

1. For treatment involving lab fees such as crowns, bridges, dentures, partial dentures, sleep apnea appliances, the initial payment will be one half of the total fee. The remaining balance is due at the time treatment is completed.

2. TMJ therapy fees are due at the initiation of treatment.

3. Payment plans are available through third party financing. Lending Club & Care Credit

4. For payment **in full** at the **start** of treatment we offer:
   - 5% courtesy for payment with cash or check
   - 3% courtesy for payment with credit card
     This courtesy is available *for treatment plans $3000 and above*
     (Lending Club and Care Credit **not** included)

   I have read and understand the above conditions and agree to accept full financial responsibility for any dental fees incurred.

   _____ _____
   SIGNATURE DATE