**Financial Policy**

Thank you for choosing Jergensen Dentistry & Orthodontics for your dental care. Our goal is to deliver the best and most comprehensive dental care available. An important part of achieving this goal is making the cost of optimal care as manageable for our patients as possible by offering several payment options.

You can choose from the following:

* Cash, Personal Check, Credit card
* Convenient monthly payment plans from Care Credit (Allows you to pay over time with no annual fees or pre-payment penalties)

Please be aware that Dr. Jergensen requires payment in full at the time of treatment unless otherwise agreed upon. In that case you may be asked to sign a patient payment agreement stating the agreed upon terms. If you have dental insurance we will expect your co-payment at the time of treatment. For treatment that requires multiple appointments, an alternate payment arrangement may be provided.

As a courtesy to our patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. We make every effort to keep your insurance information current, however we are not responsible for any changes made to your insurance plan without our knowledge. Your insurance policy is a contract between you and your insurance carrier,

in which your insurance plan is governed by your employer so it is your responsibility as the policy holder to inform us of changes to your plan, to know what your plan does or does not cover and any loss of coverage or additional coverage that you are eligible for. By signing this form you also agree to our office contacting you about account and insurance information over cell phone and email.

A $50 fee may be incurred for missed appointments or cancellations without at least 24 hour notice. There is a $15 fee for all returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need without financial burden.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient, Parent or Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient, Parent or Guardian Name (please print) Relationship to patient