

# Financial Policy

Thank you for choosing Henrickson Dental. Our primary mission is to educate our patients and deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as clear and manageable for our patients as possible by discussing all treatment needs and fees prior to beginning treatment and offering several payment options.

## Payment Options:

- Dental insurance
- Personal Check, Cash, Visa, Mastercard, American Express or Discover Card
- Payment Plans from CareCredit and Proceed
  - o Allow you to pay monthly with NO INTEREST (up to 12 months)
  - o Convenient, interest bearing, extended monthly payment plans also available
  - o No annual fees or pre-payment penalties

**For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for services rendered.**

I authorize my insurance company to pay my benefits directly to Henrickson Dental and I understand that I will be fully responsible for any outstanding balance on my account.

I understand that all services rendered to me by Henrickson Dental are my financial responsibility regardless of dental insurance policies and that my estimated fee will be due prior to starting treatment unless other financial arrangements were made ahead of time. All refunds less the cost of care received, are made promptly for over payments or if you choose to discontinue care before treatment is completed. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance. I authorize Henrickson Dental to initiate a complaint to the insurance commissioner for any reason on my behalf.

Henrickson Dental will bill my insurance company as a courtesy to me, any prior financial authorizations written or verbal do not guarantee coverage, payment or discount from my dental insurance provider.

- Final out of pocket expense is always determined after insurance processes the claim and a billing statement will follow with payment in full due within 30 days.

I understand that should my insurance company send payment to me, I will forward the payment to Henrickson Dental within 48 hours along with copies of all paperwork that was provided. I agree that if I fail to send the payment to Henrickson Dental and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies.

**A fee of \$150 per scheduled hour with doctor and \$100 with hygienist will be charged for appointments that are missed or canceled without 48-hour notice.**

Henrickson Dental charges \$50 for returned checks.

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Signature of Patient, Parent or Guardian

Date