ADVANCED FAMILY DENTAL

4145 Bedford Road
Bedford, Texas 76021
817-354-7840

1674 Keller Parkway, #180
Keller, Teas 76248
817-337-0072

FINANCIAL POLICY

Thank you for choosing us as your dental healthcare provider. We are committed to providing our patient's with the highest quality of dental care in the gentlest manner possible. Please understand that payment of your bill is considered a part of your treatment. We realize that every person's financial situation is different. We have worked hard to provide a variety of payment options.

PAYMENT: Payment is due at time of service. We accept cash, checks, visa/master/discover and cards. If you have dental insurance, your deductible and estimated co-pay/percentage is due at time of service.

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INSURANCE: Most misunderstandings about insurance can be avoided if you understand what your policy provides. It is your total responsibility to know and understand what your policy does and does not cover. We are happy to file forms to see that you receive the full benefits of your coverage. The balance is your responsibility whether your insurance pays or not. Your insurance policy is the contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid their portion within 60 days from start of treatment, you are responsible for payment at that time. Payment is due one week of receipt of our invoice. The invoice will accrue an interest rate of 1.5% per month after 30 days.

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DELINQUENT ACCOUNTS: Delinquent accounts will be reported to our collection service. You will be responsible for all collection and/or attorney fees. Please advise us if your payment will be late.

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RETURNED CHECKS: There is a $35.00 charge on all returned checks.

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CANCELLATIONS/NO SHOWS: Please help us to serve you and all of our patients better by keeping your scheduled Appointments. There is a $50.00 charge for any broken appointment without a 24-hour notice as well as for any no-show appointment.

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BY SIGNING BELOW YOU ACKNOWLEDGE YOU HAVE READ, UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

X_____ _____

Signature of Patient or Responsible Party — Date