PORTO FINO
DENTAL
FAMILY, COSMETIC, & RESTORATIVE DENTISTRY

Dental Practice Financial Policy

Financial Policy:

Thank you for choosing us as your dental care provider. The following describes our Financial Policy. Our office is committed to providing you with the best possible care. Your understanding of our financial policy is an essential element of your care and service. If you have any questions regarding any aspect of our policy, please feel free to present your question to any of our team members.

Payment for services is due at the time services are rendered.

We accept cash, debit card, and for your convenience Visa, MasterCard, American Express, Discover and 3rd party financing through Care Credit.

Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payment in advance may be required for certain treatment to reserve chair time and fund dental laboratory fees.

Deposit Policy:

Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for appointments over 1 1/2 hours, we require a deposit of half of the treatment fee to make your reservation.

Appointment Policy (for all patients):

We will work hard to accommodate appointments that fit your schedule and dental needs. We ask that you let us know about the changes 24 hours in advance. We do understand that life happens, but any missed appointment without the 24-hour call may be subject to a $75 short/no notice fee, Habitual missed appointments are grounds for dismissal from the practice.

All minor patients must be accompanied by an adult (parent or legal guardian). The adult accompanying the minor is required to pay in accordance with our policies. We do

not accept third party assignments, nor do we recognize or enforce the terms of divorce or child support decrees.

I have read and understand the Financial Policy and Appointment Policy for Porto Fino Dental. I agree to abide by these policies.

Financial Consent:

The patient (account holder) agrees to be fully responsible for the total payment of treatment performed in this office. I understand and agree to this Financial Policy and Agreement. Furthermore, I authorize the release of any information relating to this claim or any insurance information. I understand that I am responsible for all dental treatment not covered by my insurance.

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Patient Print Name Patient Signature