Financial Policy

Everkind Dental

Assignment and Release
I the undersigned, understand that it is my responsibility to present, if I choose, any dental insurance I may have to Everkind Dental so that Everkind Dental may assign all non-contracted benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges at the time of service. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Patient Agreement and Financial Policy
I hereby agree to be responsible for the costs of care provided by Everkind Dental and/or the dental team for myself or my dependent(s). **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment at the time of service to Everkind Dental is my responsibility.

I understand that there will be a $35 charge to all accounts in which a check payment is returned.

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 48 hours prior to my scheduled appointment time. ***For appointments scheduled for treatment of $500 or more, I will be required to make a reservation fee of $250 to schedule the appointment, which will be applied to my out-of-pocket expense for the appointment. This reservation fee is non-refundable. If I do not show up for my appointment or I do not give 48 hours' notice if I am unable to keep my appointment, the reservation fee will be forfeited. If I decide to reschedule my appointment after a late cancellation, I will be required to make another deposit of $250 to book. For appointments scheduled for treatment less than $500, a cancellation fee of $100 may apply if I do not provide notice of cancellation at least 48 hours prior to my appointment time.***

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that for any treatment, payment in full is due at the time of service. I understand that after 30 days, any unpaid balance will incur a $35 billing fee. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Minor/Child Consent
I, being the parent or legal guardian representing the party being treated by Everkind Dental, do hereby request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also understand that the parent or guardian who brings my child in for treatment will be responsible for payment. A receipt will be provided so I may seek reimbursement.