Financial Policy

Welcome to Horizon Dental. You have many choices when it comes to choosing a dental office, and we are glad that you have chosen us to provide you and your family with the most advance dental treatments available. Everyone at our office is committed to providing quality dental care in a comfortable environment. Please take a few minutes to familiarize yourself with our office's financial policies.

Although many dental offices are non-assignment, our office will accept direct billing of benefits from your insurance company as part of our client services.

It is important for you to understand that there may be a difference between what your insurance company will pay for treatment and what our office charges. You are responsible for any difference in fees.

In order to provide direct billing to our patients, we will require our patients to provide us with a credit card on file. If we cannot calculate your balance at your dental visit with certainty, you will be required to pay a 25% deposit following your appointment with us. This may result in a small balance or credit on your account.

Name of Credit Card Holder: _____
Credit Card Number: _____
Expiry Date: _____
Security Code: _____
Signature of Card Holder: _____

If a balance remains upon receiving payment from your insurance company, we will charge the remaining balance to the credit card on file and will notify you via telephone.

Also, in order to provide direct billing to our patients that have two insurances, we will require our patients to provide a credit card number on file. If a balance remains upon receiving payment from both insurance companies, we will charge the balance to the credit card on file and will notify you via telephone.

We hope that your experience with us will exceed your expectations. If we can help in any way, please do not hesitate to ask.

I have read and am aware of the above policies. I understand that I am responsible for the fees associated with the services I receive. Should I choose to direct bill my insurance company, I will be responsible for payment of any unpaid balance the day of service. I consent to the collections, use, and disclosure of my personal information when permitted or required by law.

_____	_____	_____
Patient/ Guardian Signature	Print Name	Date