



Financial Policy

Commercial Insurance

We are pleased to have you as our patient and we are committed to providing you with our best professional care. Your clear understanding of our financial policies is important to our relationship. If you have any questions about this or any other office policy or procedure, we will be pleased to discuss them with you. You can call us at {952} 937-5977.

We will be happy to bill your insurance carrier as a courtesy to you; however, co-payments and lab costs are due at the time of service.

Due to all the various insurance plans within each insurance company, it has become an extremely complicated process to become familiar with all the individual plans. We therefore request that all patients seek out all information needed from their insurance company and that you assume responsibility for giving this information to our office.

If your insurance has not paid its portion within 45 days, the entire account becomes your immediate financial responsibility. A monthly fee of 1.5% will be charged to accounts over 30 days old. We will gladly assist you to the best of our ability to resolve disputed claims.

CASH PATIENTS

Payment is due as services are rendered. If you need to make payment arrangements, we will sincerely assess your needs and help you choose the best plan we can, prior to your appointment.

CANCELLATIONS

To provide the best service possible we require a 24-hour notice for all cancellations. Any appointments cancelled within 24-hours will be charged a cancellation fee of \$75 per hour. Cancellations within 24-hours make it impossible to fill your appointment time and properly care for our entire patient base.

PAYMENT OPTIONS FOR ALL PATIENTS

CASH/CHECK

VISA

MASTERCARD

DISCOVER

CARE CREDIT -this is an extended payment plan. (Please ask for details!)

I, the undersigned, do hereby guarantee payment in full of all charges in consideration for dental services rendered to myself _____, and/or members of my family.
{Patient name or Responsible Party}

Signature of Responsible Party _____ Date _____

Witness {staff member at Omega Dental} _____ Date _____