BLUE HILLS
DENTAL ASSOCIATES

**340 Wood Road Suite 288**
**Braintree, MA 02184**
**781-356-2882**

# Office Financial Policy Without Insurance

- We try to make your dental care as cost-efficient as possible. One measure we have taken to keep cost down is to minimize our billing and accounting; therefore, we ask for payment at the time of service. Financial arrangements must be established before our office can continue with any recommended treatment.

- All patients who are seen in our office for a Comprehensive Exam are provided with a Treatment Plan. Our office accepts Visa, Master Card, American Express and cash as forms of payments for your treatment plan. A monthly payment arrangement, if approved for your treatment, may be made through CareCredit or Lending Club Patient Financing.

- Should your account become delinquent (past due), we will continue to send a statement until the balance is 90 days old. If your account remains delinquent, two consecutive letters will be sent in order to avoid the necessity of pursing further collection actions. Should your account remain delinquent, we will forward the balance to our collection agency.

- In cases of divorce or separation, the parent bringing the child is responsible for payment.

- **Cancellation Policy**: If it becomes necessary to reschedule your appointment, we request the courtesy of 24 hours notice. If you cancel, do not show or miss your appointment without the required notice we will assess a $25.00 non-refundable missed appointment service charge. This fee is strictly enforced.

- If you have any questions regarding your account balance or if you are experiencing circumstances beyond your control, please contact our office. We will be happy to assist you with your questions or to set up special payment arrangements.

Our practice firmly believes that a good doctor/patient relationship is based upon a clear understanding of office policies and an open line of communication. We have instructed our staff to make every effort to clarify any misunderstandings you may have concerning your account balance or our financial policies. We hope to avoid any possible disagreements over payment for professional services.

Our patients and our relationships with our patients are very important to us. If you have any questions or need assistance, please contact us immediately.

Patient Signature:_____Date:_____