LUKE W. ST. PIERRE, DDS
DARAH L. FUGETTA, DDS
general dentistry

FINANCIAL POLICY & AGREEMENT

Our goal is to provide you with the highest quality dental care using superior materials and technology. We look forward to helping provide you with up-to- date information and educational tools so that you may participate in the maintenance of your oral health. Our financial policy is intended to allow us to provide excellent service to our patients.

Please initial after reading each section.

_____ All charges you incur are your responsibility regardless of insurance coverage. You guarantee payment of all charges. **As your dental care provider our relationship is with you, our patient and not with your insurance company.** Your insurance policy is a contract between you, your employer and the insurance company. If payment from your insurance company is not received within forty-five (45) days from the date of service, you will be expected to pay the balance in full.

_____ As a courtesy to you, we will assist in processing your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing this agreement. It is the patient's responsibility to contact our office with any insurance changes.

_____ **Payment is due at the time service is provided. Unfortunately, we are unable to wait until a spending account has reimbursed you to receive payment**. Our office incurs fees at appointments such as lab fees, cost of materials, etc. Our office accepts cash, checks, American express, Mastercard, Discover and Visa. Outside financing is available for patients through CareCredit upon request and approval.

_____ You have 24 hours to cancel or reschedule your dental appointment without any penalty. Appointments that are cancelled without 48 hours notice will be charged a $50 cancellation fee. After two broken appointments, our office reserves the right to refuse services to anyone.

Please feel free to ask any questions regarding this financial policy and agreement. We are committed to providing you with a positive dental care experience.

_____   _____   _____
         Print name   Signature   Date