Necedah: 608.565.7173 **Elroy: 608.462.8282**

Thank you for the opportunity to help with your dental health care needs. We take pride in our team's education, knowledge, compassion and care-giving skills. Our practice is designed for your comfort and our team members are dedicated to making your visits enjoyable. We feel that a great relationship with our patients is essential and will always take the time to listen and answer any questions you may have.

OUR PAYMENT AND INSURANCE POLICY

♦ **Patients without insurance coverage . . .**
The fee for the treatment rendered must be paid in full on the day of service.
♦ **Patients with insurance coverage . . .**
As a courtesy, we will complete and file an insurance claim for each visit. The estimated patient copay and deductible for the treatment rendered must be paid in full on the day of service. As statement will be sent to you if there is a balance on your account after insurance has paid. These balances are due withing 30 days. Please understand that you are ultimately responsible for all fees generated by your treatment and that our office has no control over how much your insurance will pay.
♦ **We accept Visa, MasterCard, checks, and cash for payment of the amount due. We also offer financing through CareCredit which is a private lending institution.**
Payment plans are available. Please ask about them if you need one.

Past due amounts beyond 30 days will be subject to a late charge of 1.5% per month. In certain situations our office will set up payment arrangements for you. In those cases interest will not be charged as long as payments are made according to the contract. If payment is missed, interest will be applied until payment is made.

Patients will be charged $35 for any NSF checks.

OUR APPOINTMENT AND CANCELLATION POLICY

Appropriate time will be blocked off on our schedule to allow us to give you the best care possible. We will make every effort to see you on time and apologize in advance if we are delayed. We hope you will make every effort to keep your reserved appointment time.
♦ **We ask you give us 24 hours notice for canceling or rescheduling appointments.** Any patient(s) who no show or cancel without a 24 hour notice twice will be required to make a prepayment of $100 prior to their third (3rd) appointment. This money will be applied towards the patients account if they keep their appointment otherwise the amount is forfeited to Karas Dental.

If you have any questions regarding these policies please don't hesitate to call our office.

_____ _____

Patient/parent or guardian of minor patient SIGNATURE DATE

_____

Patient/parent or guardian of minor patient
PRINT NAME