Financial Policy

Thank you for choosing Prosthodontics of the Carolinas as your dental provider. Our goal is to provide you with the best possible dental care as well as effective communication. The following is a statement of our financial policy which we require you read and sign prior to starting treatment in our office.

Payment Options:

We require payment be made at the time of service unless other arrangements have been made in advance. For your convenience, payments may be made by cash, check, Visa, Master Card, Discover, or American Express. We have also contracted with CareCredit and Lending Club to provide long term financial payment arrangements.

Insurance Coverage:

Dental insurance would be more accurately described as a dental supplement. Dental benefits are not intended to pay everything, but to assist with the costs of your dental treatment. Generally, dental benefits pay a percentage of most dental procedures up to a yearly maximum. The benefits available to you are established by the plan package your employer has provided. To avoid confusion, we recommend you review your plan or call your carrier prior to having your dental treatment performed.

Patients with dental insurance coverage are responsible for their accounts in full. Insurance benefits will be paid directly to the patient from their insurance carrier as the dental insurance is a contract between you and your insurance company, not the insurance company and our practice.

For your convenience, our office will file your dental insurance claim and pre-treatment estimate if requested. Please understand you are responsible for the balance due on your account as a result of any and all professional services rendered by this office regardless of your insurance status. We are out of network for all insurance carriers.

Cancellation of Appointments:

Please give the office a minimum of 24 hour notice in the event you cannot honor your scheduled appointment. Failure to do so could result in a cancellation fee of $75.

Due to the nature of the type of dentistry our doctors provide, it is sometimes necessary to modify our patients' appointments. Please understand that our intention is to ensure the quality of dentistry you expect from our office.

I have read, understand and agree to the Prosthodontics of the Carolinas' financial policy as outlined above.

Signature_____

Relationship to patient_____ **Date**_____