Cypress Creek Dental

Thank you for choosing our office as your dental care provider. We are committed to your treatment being both a pleasant and successful experience. Please understand that payment for treatment and services rendered is considered part of your treatment. The following policy has proven to be instrumental in keeping dental care cost down for our patients by eliminating the costly administrative expenses associated with billing procedures.

We accept the following methods of payment:
Cash, Visa/MasterCard, Discover, American Express or Check
Extended payment plan
Care Credit

Insurance:
If you prefer, our office will file your insurance claim for you. This is a courtesy service we provide for our patients to help some of the often confusing paperwork associated with processing claim forms.

Please remember you insurance policy is a contract between you and your insurance company. Our office is not a party to that contract. Acceptance of insurance assignments by this office does not absolve the patient of Full responsibility for charges for treatment rendered. The estimate we provide a patient is to be considered a guideline until final insurance payment is received and the patient account is reconciled. Our office can make **No Guarantee** of the insurance payment as estimated. If payment from the insurance company is not received within 60 days, payment for the treatment will be collected from the patient. We will then provide you with the proper paperwork to have you reimbursed for your treatment through the insurance company. We are happy to be of assistance in helping you maximize your dental benefits.

Missed Appointments: *No charge will be made for rescheduling an appointment provided 48 hours notice is given. Please remember that once an appointment has been made, that this time is reserved specifically for you.*
Cancelled appointment with hygienist is a $30 fee
Cancelled appointment with the Dr. is a $50 fee

Returned checks
There will be a $30 handling fee for any returned checks

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.
I have read and agree to honor this financial policy.

X_____ X_____
Signature of patient or responsible party Date