FINANCIAL POLICY

Dr. James K. Burnham and staff are proud to be a team whose primary mission is to deliver the finest and most comprehensive periodontal services available today. Our concern is your dental health and we will offer the best treatment based on your individual needs.

For your convenience we accept the following methods of payment: cash, check, money order, Visa, Mastercard, and Discover.

For patients who will not be submitting insurance we offer a 5% discount if treatment is paid in full at time of surgery or for periodontal therapy.

For patients preferring a more extended payment option we offer CareCredit®, a health care card *specifically* designed to help patients pay for treatment and procedures not covered by insurance. CareCredit® plans include 6,12,18 month interest free monthly payments and you can select which option is best for you. Speak with one of our experienced front office staff to learn more about this option and how to apply either by phone on online.

Insurance
As a courtesy we will submit our recommended treatment plan to your insurance carrier. However, your insurance plan is specific to you, your employer, and the insurance company. Insurance is method of reimbursement and not a substitute for payment. Every effort will be made to correctly *estimate* benefits. However, contract limitations, deductibles and/or other pending claims may affect the actual payment made by your insurance carrier. Any remaining balance after insurance has been remitted to our office is the responsibility of the patient.

Account Statement
We will mail you a statement at the beginning of each month if there is a remaining balance due on your account after insurance reimbursement has been made. Any balance on your account will be due upon receipt of billing statement.

Finance Charges
Accounts are considered past due after ninety (90) days. A two percent (2%) finance fee will be assessed on the unpaid balance after ninety (90) days for each month thereafter, not paid in full. Accounts over 90 days are subject to being sent to a collection agency.

I understand that I am responsible for all costs of dental treatment regardless of what my insurance carrier may or may not pay.

Signature: _____ Date:_____