Harbor Cove Dental

123 Main Street
Gloucester, MA 01930
(978) 865-3360

Office Financial Policy

- We try to make your dental care as cost-efficient as possible. One measure we have taken to keep cost down is to minimize our billing and accounting; therefore, we ask for payment at the time of service. Financial arrangements must be established before our office can proceed with any recommended treatment.

- All patients who are seen in our office for a Comprehensive Exam are provided with a Treatment Plan. This is an **ESTIMATE** of the anticipated cost of your dental treatment. Your Treatment Plan will include an estimated insurance payment based on your dental coverage. If your carrier's payment differs from our estimate, you are responsible for the balance. In the case of an overpayment, you are entitled to a prompt refund. Any claims over 90 days, become your responsibility.

- If after insurance pays, there remains a balance on your account, you will receive a *Statement for Services*. This balance is due in full within 30 days. We will continue to send a statement each month until the balance of your account is paid in full. There is a $5.00 per month late fee applied to account balances over 30 days old. Should your account become delinquent (past due), we will continue to send a statement until the balance is 90 days old. If your account remains delinquent, two consecutive letters will be sent in order to avoid the necessity of pursing further collection actions. Should your account remain delinquent, we will forward the balance to our collection agency.

- In cases of divorce or separation, the parent bringing the child is responsible for payment.

- **Cancellation Policy**: If it becomes necessary to reschedule your appointment, we request the courtesy of 24 hours notice. If you cancel, do not show or miss your appointment without the required notice we will assess a $50.00 non-refundable missed appointment service charge. This fee is strictly enforced and will not be covered by your insurance.

- If you have any questions regarding your account balance or if you are experiencing circumstances beyond your control, please contact our office. We will be happy to assist you with your questions or to set up special payment arrangements.

Our practice firmly believes that a good doctor/patient relationship is based upon a clear understanding of office policies and an open line of communication. We have instructed our staff to make every effort to clarify any misunderstandings you may have concerning your account balance or our financial policies. We hope to avoid any possible disagreements over payment for professional services.

Our patients and our relationships with our patients are very important to us. If you have any questions or need assistance, please contact us immediately.

Patient Signature:_____ Date:_____