



## **Financial Policy**

The Center for Natural Dentistry strives to offer exceptional holistic dental care, outstanding customer service, and an unparalleled patient experience. We also want to keep our costs down and pass along the savings to you, our patients. Our regular fee for an exam and consultation is \$199 and our regular fee for digital 3D Cone Beam X-Rays is \$199. **With or without dental insurance, payment for services and products are due at time of scheduling and/or delivery of product.**

We accept the following payment methods:

- Cash
- Check (returned checks will be assessed a \$25 fee)
- Credit Card (Visa, Master Card, Discover, American Express)
- Third Party Financial Partners (Care Credit)

### **If you have dental insurance:**

As a courtesy, we will print pre-filled claims form(s) that are ready for you to submit to your insurance company. From experience, our patients are typically reimbursed by their insurance company within 2-8 weeks, depending on procedure or company. If you do not receive your reimbursement check within 8 weeks, please contact the insurance company. It is common for insurance claims to "get lost in the shuffle."

If you are not sure if "Service X" is covered by your plan, please call your insurance company first as all plans have different guidelines and regulations. Unfortunately, due to the variability of plans and coverages, The Center for Natural Dentistry cannot guarantee payment of any denomination for any procedure. In general, most dental insurance companies reimburse for substandard non-holistic treatments such as mercury amalgam fillings and it is in their best interest to pay the least amount for services and minimize claims.

If you need assistance in paying for your services, we do accept Care Credit and we will be happy to assist you with your application. Please ask anyone in the office for more information or to start the application process.

Thank you for understanding. We are pleased to have you as a patient and look forward to serving you.

The Center for Natural Dentistry

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I have read and completely understand the financial policies of The Center for Natural Dentistry. I understand I must pay for my services in full at the time services are scheduled.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_