Akbar Masood, DDS, PA

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Financial Policy

Welcome to Pearl Dental Center of Laurel Lakes! We are happy to have you as our patient and look forward to offering you and your family the finest dental care available. We know that providing complete comprehensive dental services includes discussing all treatment and financial information.

Payment is due at the time services are rendered. For your convenience we accept Visa, MasterCard, American Express, Discover, and CareCredit. Any deductible or **estimated** copayment amount will be due at the time of treatment.

Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you, your employer, and your insurance company. Your insurance coverage and benefits are your responsibility. Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. We are happy to file your claim for you if you present your dental insurance card (if available) and all required employer information. You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment.

If there have been any changes regarding your personal information (including but not limited to your home address, phone number, & email address) and insurance information it is your responsibility to let us know before or at the time of your appointment.

If payment for services already rendered has **not been paid in full within 45 days**, either by you or your insurance company, the remaining balance for your treatment is considered due and must be paid by you.

Appointments are reserved exclusively for you. As a benefit to you, our valued patient, we may offer to move your appointment to an earlier time if an opening arises. **If an appointment is not cancelled at least 48 hours in advance, or if you fail to keep your appointment you will be subject to a $100 fee.** The office reserves the right to dismiss a patient that misses an appointment.

We thank you for your cooperation.

I have read and understand this financial policy.

_____ _____

Printed Name Patient Signature

_____ _____

Witness Date