Palmetto Periodontics Financial Policy

Thank you for choosing us as your periodontal care provider. We are committed to your treatment being successful. The following is a statement of our financial policy, which we need you to read and sign prior to any treatment.

All patients must complete our Patient Information and Health History Form before being seen.

- Full payment is expected at the time of service unless you have made prior arrangements with our patient coordinator
- We accept cash, checks, Visa, Master Card, American Express and Discover
- A $40.00 service charge will be assessed for returned checks

Insurance and Workman's Compensation
We will gladly prepare all necessary forms or reports to help you obtain your benefits from insurance companies. However, we do not accept co-pay or partial payment for services rendered. Your insurance company will directly reimburse you. We do have various payment plans available so that finances are not the only thing standing between you receiving the necessary care.

Usual and Customary Rates
You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Scheduling Surgical Appointments
Due to the amount of preparation and length of time required for surgical visits, we require a minimum of five business days notice to cancel or change these appointments. Failure to give adequate notice will result in a $100 cancellation fee. In order to uphold this policy, we do require that all surgical patients leave valid credit card information on file. No amount will be charged to your credit card unless your surgery appointment is broke with less than five business days notice. This policy will be discussed with you in further detail at the time of your consultation.

Minors
The adult parents (or guardians) accompanying a minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been preauthorized and pre-paid.

Thank you for allowing us to participate in your care. Feel free to contact us with any questions or concerns.

I have read and understand the financial policy and will comply with this agreement.

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Signature of Patient or Responsible Party   Date