Katrice L. Thomas, D.M.D., P.C.

FAMILY DENTISTRY

www.katricethomasdmd.com

3845 Interstate Court • Suite 2
Montgomery, Alabama 36109
Telephone: (334) 260-7757
Fax: (334) 260-8409

FINANCIAL POLICY

1. We accept cash, most major credit cards, debit cards, and checks with proper ID. All returned checks will be charged a $30.00 fee. Payment is expected at the time of service.

2. I understand and agree that I am responsible for all charges on my account. Insurance is filed, as a courtesy, by this office. If insurance does not pay within 45 days I am responsible for the balance. Our office will gladly reimburse you when we have received the insurance payment.

3. I also understand that this office cannot make an exact estimate of the insurance benefits to be paid since it does not have access to all insurance company records and fee schedules. I am aware that after the insurance company pays all dental claims there could be a balance that must be paid by me.

4. There will be a $50.00 fee for all cancellations and broken appointments, if you do not give at least 24 hours notice. We reserve the right to dismiss a patient from our practice after three consecutive broken appointments, habitually cancelled and rescheduled appointments, uncooperative patients and non-compliance of recommended treatment. We strive to provide quality dentistry for all patients and broken and rescheduled appointments hinder our efforts and desires to render these services.

5. There will be a 1.5% finance charge added to all accounts over 30 days past due regardless of whether the balance is outstanding insurance claims or co-payments due by the patients. To avoid this charge, you may pay your bill in full and we will gladly reimburse you upon receiving your insurance payment.

6. I AM AWARE AND UNDERSTAND THAT SHOULD MY ACCOUNT BE REFERRED TO AN ATTORNEY FOR COLLECTION, I WILL BE RESPONSIBLE FOR ALL ATTORNEY'S FEES AND COLLECTION EXPENSES INCURRED.

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Patient's Signature

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Today's Date