Financial Policy

Our goal is to provide you with the best possible dental care and to avoid any misunderstandings. We encourage our patients to discuss any questions they may have regarding our policies. If any problems arise, please discuss them with us promptly. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment:

1. We require that payment be made at the time of service. Payment can be made by cash, Visa, Discover, American Express, or MasterCard.
2. If the cost of treatment is $500 or less, the entire amount is due in full at the time the initial treatment is performed.
3. If the cost of treatment is more than $500, payment is as follows:
   a) At least **half** of the total cost is due at the time of initial treatment.
   b) The remaining balance can be made in equal monthly installments over the term of treatment. The balance is due in full at the time of final impressions.
4. We do offer and accept third party financing through CareCredit. The office, however, does not offer in-house financing.

Insurance. Patients who have dental insurance need to understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Your insurance is a contract between you and your insurance company. We are not a part of that contract. Our office will not accept or file any insurance claims. Reduction or rejection of your claim by your insurance company will not relieve the financial obligation you have incurred in our office.

Photography. Please note that intra- and extra-oral pictures or videos may be taken during your treatment. These pictures/videos may be utilized by Madison Prosthodontics: Aesthetic and Reconstructive Dentistry for educational, research, advancement of medicine/dentistry, and/or commercial use, including but not limited to being used in brochures, print ads, internet ads, social media sites, television ads, and placement on the practice website.

_____ Yes, I give consent for photography/video use
_____ No, I elect my photos not to be used

If you are unable to keep your scheduled appointment please contact the office at least 24 hours prior to avoid the $60 no show charge.

I, the undersigned, have read completely and agree to the terms of this financial policy and give my consent to use any photographs for teaching or training purposes.

_____ _____
Patient or Guardian Signature Date