PS

Preston Sherry
Dental Associates
Cosmetic and Implant Dentistry

6134 Sherry Lane
Dallas, Texas 75225
Tel: 214-691-7371
Fax: 214-691-2281

FINANCIAL POLICY

Payment:

Payment is due at time of service. We cannot accept post-dated checks. We do accept cash, personal checks, major credit cards, debit cards and third-party financing. We also offer Care Credit interest-free financing as well as CompassionalteHealthCare Services with approved application.

Returned Checks:

All returned checks are subject to a $50 returned check fee.

Insurance:

As a courtesy to our patients, we are happy to file your claims on your behalf. We will make every reasonable effort to collect covered amounts from your insurance company. Deductibles, co-payments and non-covered amounts are due at the time services are rendered. All estimates quoted are based upon information provided to us by your insurance company and are estimates only and are not a guarantee of payment. We are not responsible for the benefit information that your dental insurance company has provided to us. The patient is ultimately responsible for all changes incurred. After 60 days, any unpaid claims will become your responsibility. We ask that you leave a credit card on file for any unpaid balance.

We do not file secondary, COBRA or supplementary dental insurance.

Cancellations:

It is the philosophy of our office to provide optimal patient care. All patients are seen by appointment only. This allows us to focus our efforts on caring for and treating our patients to the best of our abilities. Thus, we require a minimum of 48 hours notice for cancellations and reschedules. This is necessary to allow us adequate time to notify patients who are on a waiting list for the first available appointment. Lack of adequate notice inhibits us from offering an exceptional standard of care to our other patients. You may be subject to a fee for failed appointments or inadequate notice of cancellation.

I have read the above and I understand and agree to these terms regarding my treatment by Preston Sherry Dental Associates.

Patient Signature _____**Date** _____