



**DR. EMILY BATSON**  
DENTISTRY & PROSTHODONTICS

## FINANCIAL POLICIES

In order to provide you with the best possible experience, it is necessary to communicate clearly the financial policies and missed appointment policies for Dr. Emily Batson. Please note that Dr. Batson is committed to providing the highest standards for dental treatment while keeping your out of pocket costs as low as possible. You will be given an estimate for treatment solutions recommended for you, including extensive dental treatment, exams, cleanings, and x-rays. If you have not been given an estimate or have questions regarding your care please ask a staff member promptly so we can prepare that for you.

Accepted methods of payment: Cash, Check, Visa/Mastercard/Discover, Care Credit/Lending Club

**Payment is due at the time that services are rendered.** For dental treatment totaling greater than \$1,000 we are happy to provide a 5% discount for treatment paid in full by cash or check, and a 2% discount for treatment paid in full by credit card. We are unable to offer any discounts for treatment paid through Care Credit or Lending Club.

### RETURNED CHECK FEE:

For checks returned for Non-Sufficient Funds, we will charge a service fee of \$25 to your account.

### FOR PATIENTS WITH DENTAL INSURANCE:

Dr. Batson has elected to participate as an "out-of-network" provider for all dental insurance companies, however, as a courtesy to you we will assist in filing claims to your insurance provider such that you may receive your entitled benefits from your dental insurance company. In the event that your dental insurance company requires Dr. Emily Batson accept assignment of benefits, we will issue you a refund check assuming your treatment has been paid in full.

Your dental insurance policy is a contract between you and the insurance company.

### MISSED APPOINTMENT/FAILED APPOINTMENT POLICY:

Should you need to reschedule or cancel your appointment, we require a 48-hour advance notice, so that we may assist other patients in need. We reserve the right to charge \$50 for a late cancellation or no-show appointment. Patients failing three or more appointments may be dismissed from the practice.

Signature of Patient (or parent of minor) \_\_\_\_\_ Date \_\_\_\_\_