

K. Mike Dossett DDS

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FINANCE POLICY FOR OUR DENTAL PATIENTS

It is our goal to provide the best possible dental care for you and at the same time avoid any confusion regarding our financial policy. We promise to provide you, in advance of treatment, with the amount of payment that will be required. This way you have the opportunity to discuss treatment alternatives or payment arrangements if finances are a concern.

REGARDING FINANCIAL ASSISTANCE

We do realize that, on occasion, financial circumstances can make payment difficult. If you have a financial concern, we ask that you speak with our financial manager. We accept MasterCard, Visa, American Express and Discover. We have also made it possible for patients to arrange for financial assistance.

REGARDING CANCELLATION OF APPOINTMENT & EMERGENCY CARE

We reserve time for our patients so that we can give the time and attention to each patient that they deserve. We ask that you notify our office 48 hours in advance if circumstances require you to change your appointment. Should you have a dental emergency, please call our office in advance of coming. We will appoint you as quickly as our schedule permits. If your emergency is after hours, simply call our office number and leave a complete message on our answering machine. We will contact you immediately the next business day.

FINANCIAL RESPONSIBILITY AGREEMENT

The agreement for treatment and payment is between the patient and our office. The charges, therefore, are your responsibility. In the event of non-payment, the patient agrees to pay all the costs of collection, including but not limited to attorney fees, court costs, collection agency fees, etc. If a check is dishonored or returned for any reason, you agree to cover any return check fees placed on this office. Your usage of a check for payment is your acceptance of this agreement and its terms.

I have read and understood the financial policy of this practice and I agree its terms. I also understand and agree that such terms may be amended from time to time by the dental practice.

Patient/Responsible Party Signature

Date