

Financial Policy
Kenneth R. Brown, D.D.S.
Family Dentistry

Thank you for choosing us as your dental health provider. We are committed to your treatment being successful. Please understand that payment on your bill is considered a part of your treatment. The following is a statement of our FINANCIAL POLICY that we require you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before being seen in our office.

PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER, AND
AMERICAN EXPRESS.

New patients are required to pay either cash or credit card.

Regarding insurance:

Self Insured Policy:

- The balance is your responsibility whether your insurance pays or not.
- We cannot bill your insurance company unless you provide us with the necessary information. Your insurance is a contract between you and your insurance company. We are not part of that contract.
- To serve you better, we file your insurance at time of service, as a courtesy.
- Please be aware that some, and perhaps all, of the services provided may be non-covered services by your insurance company.
- Our practice is committed to providing the best treatment for our patients. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

If you are a new patient wishing to see Dr. Brown, we will gladly file to your insurance carrier, but payment is expected in cash or credit card and due at time of service.

Those who carry no insurance are required to pay when services are rendered.

Divorce decrees are only binding upon the two parties who made the agreement. It is our policy that the parent or guardian accompanying the patient is the responsible party.

Thank you for understanding our FINANCIAL POLICY. Please let us know if you have any questions or concerns. I have read the financial policy. I understand and agree to this financial policy.

Signature of Responsible Party

Date

Kenneth R Brown DDS, PA
10960 Winds Crossing Drive, Suite 100
Charlotte, NC 28273

CANCELLATION POLICY:

Our office strives to reserve dental appointments that accommodate your personal schedule as much as possible. Should you be unable to keep your reserved appointment, we reserve the right to request sufficient notice (24 hours), so that we may appoint someone else who is waiting for our care. Otherwise we reserve the right to charge a \$50.00 cancellation fee that must be paid before further appointments are made in this office.

Thank you for your consideration in this matter.

Patient Signature _____ date _____