ROBERT J. LAND, D.D.S.
Our Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment. All patients must complete our Patient Information and Insurance form before seeing the doctor.

PAYMENT IS REQUIRED AT TIME OF SERVICE
We accept: Cash, Checks, Visa, Master Card, American Express and Discovery Card

Regarding Indemnity Insurance

We will submit your dental claim for you. However, you are required to pay your estimated co-payment at the time of treatment. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. As your chosen healthcare provider, we are not a party to that contract. Please be aware that some, and perhaps all of the services provided may not be a covered service, and not considered reasonable and necessary under your insurance plan.

Collection Policy

If we have tried to collect from you without success, and have to turn your account over to a collection agency there will be an additional fifty; (50%) percent charge by the collection agency in addition to the balance of what you owe.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients

Patients are responsible for payment at time of treatment.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, i.e. Visa/Master Card, or payment by cash or check at time of service has been verified.

Missed appointments

Unless your appointment is cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit ($50.00) please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions, or concerns.

I have read the Financial Policy and I understand and agree to this Financial Policy.

X _____ Date: _____
Signature of Patient or Responsible Party

X _____
Please Print Name