William D. Bateman, DMD
General Dentistry

Our Financial Policy

Thank you for choosing William D. Bateman, DMD for your dental care. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Our primary mission is to deliver the best and most comprehensive care available. Financial consideration should not be an obstacle to obtaining this important, life-enhancing care. We are available to answer your questions or assist you in any way we can.

All of our fees are due and payable at the time services are rendered. We accept cash, personal checks or credit cards (MC, Visa, Discover or American Express). We offer Care Credit as our financing option. Care Credit is an interest free credit line. Monthly payment options up to 12 months are available based on the cost of treatment. Extended payment plan options of 24-60 months are also available with low interest rates.

For our sedation cases, or an appointment that is scheduled for 2 hours or longer, we require a non-refundable $500 deposit. The deposit will be forfeited if the appointment is missed or we do not receive 48 hours notice for changing or canceling the appointment. The $500 deposit will be applied to the patient portion of the treatment cost. For our standard appointments there will be a $50 per hour charge for any broken appointment or appointment not canceled or rescheduled with at least **24 hours notice. $25 will be charged for all returned checks.**

For our patients with dental insurance: We are happy to file the necessary forms to help you receive the full benefits of your coverage. The insurance relationship constitutes an agreement between the patient and the carrier. As such, we can make no guarantee of estimated coverage or payment. Your estimated portion for treatment is due at the time services are rendered. Because we cannot guarantee your exact insurance coverage, there may be a balance remaining after insurance pays.

I, ___________________________, understand that any insurance coverage estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office. Any insurance claim not paid in full after 60 days will become my responsibility to pay at that time.

Patient (or responsible party) Signature: _____________________________________ Date: ____________

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