

**W. Tyler Mistr, DDS
Nancy C. Bollinger, DDS**

Our Financial and Office Policy

Thank you for choosing Dr. Tyler Mistr and Dr. Nancy Bollinger as your dental providers. We are committed to providing quality treatment at reasonable costs to you. The following are conditions of our office's financial policy.

Insurance

We do not participate with any dental insurance companies. As a courtesy we will file the insurance claim on your behalf, including any x-rays and narratives that may be necessary. Your insurance company will reimburse you for any amount they cover. Your treatment recommendations are based on your dental needs, not on what your insurance benefits are.

Broken appointments and No shows

Our office operates on a very high hourly overhead cost basis and requires a 24 working hour cancellation notice. There is a charge **\$30 per half-hour** of your scheduled appointment time for which you did not appear. This must be paid before any further appointments will be scheduled. For those appointment times of 3 hours or more, we require a 20% deposit the day the appointment is made. This fee is applied toward your expense the day of treatment. If you should cancel without a 24 working hour notice or no show for this appointment, this fee is non-refundable.

Collections

Our policy requires full payment is due at the time of service. We accept cash, checks, VISA/MasterCard, Discover and American Express. We also offer CareCredit Financing and Dental Fee Plan for those who qualify.

Delinquent accounts will be sent to collections if your account is not paid within 90 days of treatment. You are responsible for any/all legal fees, collection fees, interest charges and other expenses incurred in collecting your account.

We reserve the right to charge 1.5% monthly finance charge on account balances which are 30 days or more past due.

We reserve the right to charge a \$25 returned check fee for any and all check returned to our office from your financial institution for lack of payment.

Notice of Privacy Practices Acknowledgement

I hereby acknowledge that I have read a copy of the Notice of Privacy Practices. I understand that I may have questions pertaining to this Notice and I am entitled to receive a copy if requested.

I have read, understand and agree to this Financial Policy, Office Policy and Notice of Privacy.

Signature of Patient/Responsible Party

Date