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FINANCIAL POLICY

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

All patients must complete our information and insurance form before seeing the doctor:

Payment is due at the time of service.
We accept cash, checks, Discover, Master Card and Visa.

Regarding insurance:

We may accept assignment of benefits with your first visit. However, we do require your deductible and co-payments to be paid at the time of service. The balance is your responsibility whether your insurance pays or not. Your insurance policy is a contract between you and that company. We are not a party of that contract. Please be aware that some, and perhaps all of the services provided may be noncovered and not considered reasonable and necessary under your insurance.

Usual and customary rates:

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

Minor Patients: The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. Unaccompanied minors, a statement will be given at the time of service. The bill is expected to be paid within 10 days unless charges have been preauthorized to an approved credit card, or payment by cash or check at the time of service.

Missed Appointments: Unless canceled, at least 48 hours in advance, our policy is to charge \$25.00 per. hour for missed appointments. Please help us serve you better by keeping scheduled appointments.

I have read and agree to this Financial Policy:

X _____
Signature of Patient/Responsible Party

Date _____