# Daron P. Etie, D.D.S.

*To help us help you with the costs associated with your care we have developed the following financial policy. We want to make your visit with us a pleasant one. Please read and sign a copy of this before we provide any treatment.*

## Insured Patients

We welcome all patients and accept many but not all insurance plans. Please be aware that all insurance copayments, deductibles and non-covered charges need to be paid in full at the time service. This will require you to present a current insurance card. If you present an expired card or inaccurate information we will be unable to bill your insurance company, and you will be responsible for the total amount of billed services. It is your responsibility to know your insurance plan and provide the necessary information to our office. If you are unsure as to whether a procedure is covered or if your are in doubt as to whether Dr.Etie is a contracted provider, please call your plan's member services department prior to the service. Our office cannot be responsible for out-of-pocket expenses incurred as a result of utilizing the wrong provider or receiving services that are not covered by your insurance company.

## Uninsured Patients

We welcome our uninsured patients. Please know that payment in full is due at the time of service for all office visits and/or procedures.

## Minor Patients

The adult who accompanies a minor patient is responsible for payment of wervices rendered. Dr. Etie cannot be responsible for billing or collecting from another party other than filing to the appropriate insurance company, if applicable.

## Payment

Our office accepts cash, checks, credit, debit and Health Savings accounts. A convenience fee of 3.5% will be charged on all credit/debit card transactions. We do not accept CareCredit. There is a $30 fee for all returned checks.

## Missed Appointments

In the event that you fail to keep a scheduled appointment without canceling 24 hours prior, you will be assessed a fee that must be paid before you can be rescheduled in our office. The fee will be based on the length of the appointment and procedures that were scheduled.

*I certify that I have read and understand the office policies contained in this document.*

**Signature:_____**

**Date:_____**