InVision Perio
Periodontal & Implant Care Specialists
financial and privacy policy

Thank-you for choosing us as your periodontal health care provider. We are committed to successful completion and/or maintenance of your periodontal treatment. Please understand that payment of your bill is considered part of your treatment.

Payment Due
Payment is due at the time services are rendered. If you have dental benefits you will be required to pay any deductible, co-payment or pre-determined fees that apply to your appointment. We accept cash, check, VISA and MASTERCARD.

TREATMENT PLANS ARE SUBJECT TO A 20% CANCELLATION/RESCHEDULING FEE (maximum $200).
WE REQUIRE 10 BUSINESS DAYS TO CANCEL OR RESCHEDULE your treatment.

Regarding Dental Benefit Plans
As a service to our patients, we assist with benefits processing. We make every effort to maximize your dental benefits. We will provide you with a complete treatment plan before any treatment is initiated.

You may need pre-determination from your benefit plan prior to starting treatment and we will be happy to submit a pre-determination for you. If you decide to proceed with treatment without pre-determination you will be responsible for the full cost of treatment on the day of service.

If your plan has not paid within 60 days after service is rendered, you will be responsible for your account balance.

Cancellations or Missed Appointments
There will be a **20% charge (maximum $200)** if a **TREATMENT PLAN** appointment is **canceled or rescheduled with less than 10 business days notice**.

A charge of **$41** will apply to any **CLEANING OR EXAM** appointment that is **canceled or rescheduled with less than 48 hours notice (2 business days).**

Federal Truth in Lending Disclosure Statement
A service charge will be added if a balance due is not paid within 60 days. Effective 1/1/2009, the percentage rate is 2% per month. This is true annual interest rate of 24%. This also applies to all accounts with dental benefit payments pending, beginning 60 days after treatment has been provided.

Protection of Your Privacy
Our policy is to keep your health information secure and confidential. Each patient will be given a copy of our Privacy Policy along with a copy of your signed Financial and Privacy Policy.

I understand and agree to the Financial and Privacy Policy.

_____ _____
patient, parent or guardian signature **date**