Maxine Moncrieffe, D.D.S., P.A Family & Esthetic Dentistry

Office Financial Policy

Dr. Moncrieffe 's philosophy is to provide the best, most comprehensive treatment to all our patients and help them achieve optimum dental health, self confidence and a beautiful smile. We are a practice that listens to your concerns and provide various educational Medias to assist you in understanding your needs. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment is due at the time of service. Please confirm your financial obligations at the reception area before proceeding to the treatment are if you have any doubts. We accept cash, personal checks, MasterCard, Visa, Discover and American Express.

Dental Insurance

Dental insurance is a contract between you, your employer and your insurance company. We will file your insurance claims as courtesy to you; however, all charges are your responsibility from the date the services is rendered. Any portion of your treatment not covered by your insurance will be reflected in your billing statement. We must emphasize that as a Dental Provider our relationship is with you and not your insurance company.

Outstanding Balances

All outstanding balances over 90 days will incur a 1.5% monthly financial charge (18% annually). Balances over 120 days will be forwarded to American Credit Bureau unless proper payment arrangements have been made. Please contact our office if you have any questions about your accounts.

Cancellation Policy

Your appointment time is specifically reserved in order to provide you with the high level of treatment you expect and deserve, we kindly request 48 hours of notice to reschedule an appointment. Failure to show for scheduled appointment or contact our office 24 hours prior to your appointment to reschedule will result in $50.00 missed appointment fee.

If you have any questions regarding the above information, or your insurance coverage, please ask us, we are here to help. Thank you for choosing our office to fill your dental needs.

I have read and fully understand your office Financial and Cancellation Policies

Signature of patient _____ *Date*_____