CROSS POINT FAMILY DENTAL
850 Chelmsford Street
Lowell, MA 01851

Financial Policy

Thank you for choosing CrossPoint Family Dental for your dental needs. In an effort to provide quality care to our patients and avoid any misunderstandings, we would like to inform you of our office policy regarding payment for services rendered.

Payment is expected at the time treatment is performed. As a courtesy to our patients with dental benefits, we will submit your claim to your insurance company. Any portion not expected to be covered by these benefits is the responsibility of the patient and due at the time of service. This amount will include deductibles and co-payments. If benefit amounts are less than expected, you will be billed for the difference.

Dental benefits are contracts between the ***policy holder*** and the ***insurance company***, ***not our office.*** We will make every effort to assist you with any benefit questions however, we suggest that you be aware of what benefits you have available. Ultimately, you are responsible for the balance.

Dental insurance usually does not cover the total cost of your treatment. Based on your plan, we usually can estimate the amount of your co-payment. When treatment is rendered, your co-payment will be expected at that time. **If your insurance company fails to pay within 60 days after we submit your claim, you will be responsible for the full fee.**

Marital status is not a consideration under any circumstance. The parent accompanying the child/minor on the day of service will be considered the responsible party. We will gladly provide you with copies of statements for reimbursement.

There is a $25.00 charge for returned checks.

For your convenience, we accept most major credit cards. **We do not accept monthly payment plans in our office. We do have a credit company that can assist you with monthly payments...please ask the front desk.**

Broken Appointment Policy
CrossPoint Family Dental requires 24-hour notice for cancellation or rescheduling of an appointment. If 24 hours is not given, a broken appointment fee will be charged.

Notice of Privacy Practices (HIPPA)
I have received a copy of this office's Notice Of Privacy Practices.

By signing below, you understand and accept the terms of our **Financial Policy, Broken Appointment Policy,** and receipt of our **Privacy Practices**.

Signature of Responsible Party _____ Date _____
Patient, Parent, or Legal Guardian