Jon W. Williamson D.D.S.
262 Hickerson Street
Cedar Hill, TX 75104

Our Financial Policy

Dear Patient:

Thank you for choosing us as your dental health care provider. Our main concern is that you receive the proper and optimal treatments needed to restore your dental health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask.

We ask that all our patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the doctor.

Payment is due at the time services are rendered. We accept cash, checks and for your convenience, Discover, Mastercard and Visa.

In the event that a balance is left on your account, please be aware that this office does not send monthly statements. Our office handles all collections by phone. Therfore, if you move please try to provide us with your new address and telephone number. If a statement must be sent, a fee of $10.00 will be added per account for each monthly statement sent.

As a courtesy to you, we will be more than happy to process your insurance claim for you as long as your portion of the claim form has been completed. However you must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you not your insurance company.

2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

3. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.

4. If the insurance company does not pay your balance in full within 30 days, we may ask that you contact the carrier to help speed things up.

5. Returned checks are subject to a fee of $25.00.

Please note that, unless canceled at least 24 hours in advance, you may be charged for missed appointments at the rate of a normal office visit. Please call if you must reschedule.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing us as your dental health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you with the best possible care.

Signature ____________________________ Date______________