Mark King DMD, PSC
107 Frazier Ct. Suite 1D
Georgetown KY 40324
(859)-987-3396

FINANCIAL POLICY

Patient name:_____ DOB_____
SSN_____

Thank you for choosing us for your dental care. We are committed to providing you with the best possible treatment. Your clear understanding of our financial policy is important in providing you with informed care.

Regarding Insurance
Your insurance is a contract between you, your employer and the insurance company. We are not a party to the contract. We cannot guarantee payment or claims. You are responsible for your treatment. The policyholder must handle any disputed claim or non-payment of a claim with the insurance company. We will gladly file your insurance as a courtesy however; your payment and deductible will be due at time of service.

Payment Arrangements
Full payment is expected at time of your treatment. Our office presents you with several different payment options to assist you in paying for your dental treatment. Options are cash, check and credit card. In the event that a check written to our office were to have insufficient funds there will be a $25 dollar charge in addition to the original amount, or as determined by our legal affiliate.

By signing this document you agree that you read and understand all information regarding this financial policy. Acceptance of treatment implies consent to pay all of the cost involved in said treatment. This includes any attorney fees and costs incurred in the collection of delinquent charges.

_____ _____
Patient signature (parent if under 18) Date