Cooley Cosmetic & Family Dentistry, P.C.
Chet Cooley, D.D.S.
3905 University Blvd., Ste.#200
Tyler TX 75701
Business Line: (903) 592-6535

Regarding Dental Insurance ~

Please note that the information provided to us by your insurance company is not a guarantee of payment, and the patient is ultimately responsible for their treatment costs, regardless of what insurance pays. We will do our best to obtain accurate benefit information from your insurance company, so that we may ***estimate*** what your portion will be at each visit. For patients with dental insurance through companies for which we are ***not*** providers, please understand that our treatment fees are not necessarily the same as the fees your insurance company allows; thus there may be a balance due even when insurance claims to pay 100% as payment will be based on ***their* fee schedule**, **not ours**. The portion collected at the time of treatment is only an **estimate**; the responsible party will be invoiced for any balance that remains after insurance pays. If you have questions regarding insurance, please feel free to ask our office manager.

THERE WILL BE A $50 CHARGE FOR ALL MISSED AND LATE CANCELLED APPOINTMENTS WITHOUT AT LEAST 24 HOURS NOTICE.

Please note there will be a **$50 fee for returned checks**.

PATIENTS WILL BE ASKED TO PAY ½ OF THEIR PATIENT PORTION TO RESERVE ANY TREATMENT TIME LONGER THAN 1 HOUR

Our Financial Policy

Payment for all services is expected at the time the service is provided. We accept cash, money orders, and personal checks as well as credit card payments made with Visa, MasterCard, Discover, American Express or Care Credit.

DISCOUNTS FOR PATIENTS WITHOUT INSURANCE COVERAGE:

5% DISCOUNT FOR ALL PATIENTS PAYING WITH (DEBIT CARDS, VISA, MASTER CARD, DISCOVER OR AMERICAN EXPRESS)
10% DISCOUNT FOR ALL PATIENTS PAYING WITH (CASH, CHECK OR MONEY ORDER)

I understand and agree that all services rendered to me, my dependents, or others assigned by me to my account are charged directly to me and that I am responsible for payment. I understand that a monthly finance charge will be applied to any past due balances, and accounts unpaid after 90 days will be reviewed for submission to a collection agency. If at any time I decide to suspend or terminate the care being provided to me or to those whom I have declared financial dependents, any fees for services that have been completed are immediately due and payable.

______________________________ ______________
Patient (Parent/Guardian) Signature Date