Bradford Fisher, DDS
207 7th Avenue South
Nampa, Idaho 83651
442-0000

FINANCIAL POLICY

Thank you for choosing Dr. Bradford B. Fisher, D.D.S. for your dental needs. We are committed to providing quality dental care for you and your family. Please read the following information, and if you understand our financial policy please sign in the space provided. We will furnish you a copy at your request.

Payment for dental services is expected at the time of service. Our office welcomes Visa, Mastercard, Discover, CareCredit, Help Card, personal checks, and cash.

For patients needing an extended payment plan we offer Care Credit and Help Card (healthcare credit cards). A simple application is submitted and within minutes, if approved, you will have a line of credit for dental care with low monthly payments and up to twelve months to pay interest free in some cases.

Our office is happy to submit dental claims on your behalf. Your insurance company may need you to supply certain information directly to them. It is your responsibility to respond to their request. Your insurance benefit is a contract between you, your insurance company, and your employer. Anticipation of benefits expected are clearly estimates. The actual balance due after the insurance payment is the responsibility of those seeking treatment.

Please help us serve you better by keeping your regularly scheduled appointment. If you are unable to keep your appointment, please give us a call so we may reschedule. You must give 24 hours notice if you cannot keep your scheduled appointment. A $30.00 fee will be charged to your account for any missed appointment.

Accounts past due will have an accrued service fee at the rate of 1.0% per month. If you desire, we will automatically charge your monthly payment to your credit card each month. If an unforeseen situation should arise that prevents you from making your monthly payment in a timely manner, please contact our office to avoid any misunderstanding.

Our dental practice is committed to excellence. Our goal is to provide the best dental care possible. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of Patient or Responsible Party   Date

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