Financial Policy

Thank you for choosing Martin N. Baker DDS PA. Our primary mission is to deliver the highest quality dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible.

Payment is expected at the time dental treatment is provided.

Payment Options:

- Cash, Check or Visa, MasterCard, Discover or American Express
  - We offer a 5% courtesy accounting adjustment to patients who pay for their treatment in full with cash or check prior to the start of treatment plans of $1000 or more.
- Convenient Monthly Payment Plans from CareCredit[1]
  - Allow you to pay over time, no annual fees or pre-payment penalties

Dental Insurance: For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. We do our best to provide each patient with an accurate estimate of their portion, however any quoted amounts are subject to change based on your insurance company's reimbursement[2].

For emergency appointments, we ask that you prepared to pay in full for any treatment.

For treatment requiring multiple appointments, alternative payment arrangement may be proved. If you need more information regarding payment arrangement, please contact our front office and they will provide you with more information.

Broken Appointment Policy

In order to be respectful of every patient's time we ask that you notify our office of any cancellations at least 24 hours prior to your appointment time. Missed or failed appointments without sufficient notice leave spaces in our schedule where other patients in our dental family could have their needs addressed. We understand that emergencies happen, however multiple missed appointments will prohibit us from rescheduling future appointments.

Returned Checks: Martin N. Baker, DDS PA charges $25 fee for returned checks.

I acknowledge that I understand and have received a copy of the financial policy.

Printed Name: ______________________________

Signature: __________________________________ Date: ____________________

[1]CareCredit is subject to credit approval
[2]Any treatment fees for which we have not received payment from the insurance carrier within 90 days will be responsibility of the patient, the patient may then collect their benefits directly from their insurance carrier

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