

FINANCIAL POLICY

We are proud to be a dental team whose primary mission is to deliver the finest and most comprehensive dental services available today. We are concerned about your dental care and want to ensure that it will be performed in a caring and responsible manner. In order to assist you, we are providing the following options regarding payment of your dental services.

1. **Cash or Check** - When treatment rendered of \$1000.00 or more is **pre-paid** (paid in full prior to the start of treatment), a **5% discount** is available. This does not apply to credit card payments.
2. **Insurance*** – We will bill your insurance company as a courtesy. However, you are ultimately responsible for payment of the services we provide.
3. We accept these **credit/charge cards** as your limit allows:
American Express® Visa® / MasterCard® DISC●VER®
4. **CareCreditsm** - A Family Health Care Card – Ask us about it!

Note: Full payment is due when services are rendered.

* We understand the value of insurance benefits and will assist you in obtaining your maximum benefit. We will gladly process your insurance claim for you, and will also estimate your deductible and the portion that is not payable by insurance. That portion is due at the time of treatment, and may be paid by the options above. Our pre-estimates are subject to final approval by your insurance company, and therefore could change the amount due our office.

Quoted Fees: Treatment fee estimates will be honored if quoted treatment is completed six (6) months from the date of the initial visit.

Additional Charges:

1. No Show = \$50.00 / half (½) hour of a scheduled appointment.
2. Cancellation = \$50.00 if less than a 24 hour notice is provided.
3. Returned Checks = \$20.00
4. Late Fee Charge = \$10.00
5. A service charge of 18.00% APR. will be assessed on accounts with unpaid balances over sixty (60) days.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. If my account becomes delinquent I agree to pay a service charge of one and one-half (1 ½%) percent per month (18% annual rate) on any sums due which remain unpaid for more than sixty (60) days. I also agree to pay attorney fees, or court costs involved in the collection of my outstanding balance. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature: _____

Date: _____