

Our Financial Policy

Patient Name _____

Date _____

Thank you for choosing our office for your dental needs. Dental treatment is an investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are always available to answer your questions and/or assist you in any way we can.

Fees less than \$300.00 are due and payable at the time of treatment is rendered. We accept cash, personal checks, or credit cards (MC, Visa, Discover, and American Express).

For our patients with dental insurance: We are happy to assist you in filling the necessary forms to help you receive the full benefit of your coverage. The insurance relationship constitutes an agreement between the carrier and the patient. As such, we can make no guarantee of estimated coverage or payment. However, please know that we will do everything possible to see that you receive the full benefit of your policy.

Payment Options

Total Treatment Estimate: _____ Insurance Estimate: _____ Portion Payment _____

1. Prepayment Courtesy: Only available when not using Care Credit

We are happy to offer a 5% discount for all treatment over \$500 that is paid in full prior to treatment commencing.

\$ _____	\$ _____	\$ _____
Discount	Adjusted Total	Must be paid By

2. Payment as service is rendered:

If you wish to pay the estimated amount for treatment at the time services are rendered, we gladly accept cash, personal checks, and most major credit card. Because we cannot guarantee your exact insurance coverage, there may be a balance remaining after the insurance payment is received. Whenever choosing this option, we ask that you leave a credit card on file for any balance that may not be covered.

3. Monthly payment plans:

"Same as Cash" Interest FREE credit line (Care Credit) \$ _____
Monthly payments (up to 12 months) Interest free Monthly Total

2 Equal Payments 1/2 Down \$ _____ 1/2 @ completion \$ _____

3 Equal payments \$ _____ \$ _____
25% initial down payment Down Payment 3 monthly payments
Guaranteed with major credit card

I, _____, understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependants in this dental office. Any insurance claims not paid in full after 60 days will become my responsibility to pay at that time.

Patient (or Responsible Party) Signature: _____ Date: _____

Financial Coordinators Signature: _____ Date: _____