FINANCIAL OPTIONS

Our commitment is to provide quality dental care to the entire family through exceptional service and the utilization of advanced technology.

METHODS OF PAYMENT

1. Cash, Check or Credit Card (MasterCard, VISA, American Express and Discover)
2. Dental Insurance (described below)
3. EFT – Electronic Funds Transfer (automatic monthly deduction from your checking or savings account)
4. 5% Paid in Full Discount for CASH patients with NO Insurance can only be applied if patient share is **$1,000 or greater** and must be paid via CASH or DEBIT card with PIN #. A Discount can be given to patients paying via check, but check payment must be made **14+ days** in advance of treatment date to allow sufficient time for check to clear the bank.
5. Outside Financing (applications available)

DENTAL INSURANCE

1. We are pleased you have dental insurance and our office will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer and the insurance company. **We will need you to bring us a copy of your benefits booklet if you would like help in interpreting your benefits.**
2. As a courtesy to you, we will file your insurance and accept assignment of benefits if you have signed the insurance payment authorization form. We ask that your estimated co-payment and deductible be paid at the time of service.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover.

RELATED INFORMATION

1. Returned checks and balances older than 90 days may be subject to additional collection fees and interest charges of 1.5% per month, or 18% annually. These additional fees will be applied to the unpaid balance at the end of the month.
2. In the event that the account is not paid and we refer the account to collection, you will be responsible for all fees incurred for collection of your bill (i.e., attorney fees, court costs and collection agency fees).
3. Your appointment time has been reserved exclusively for you. Any change in your appointment affects many patients. 48 hour notice is needed to avoid a charge.

I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered.

NAME (Please Print) _____

SIGNATURE _____ DATE _____