

## **Financial Policy and Agreement**

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care. Our convenient financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patient's financial capabilities.

### **Payment**

Payment in full is due at the time of service unless prior financial arrangements are made. We offer several payment options:

- Cash, Checks, VISA, MasterCard, and Discover
- Pre-payments discounts
- No interest monthly payment plans through CareCredit or Springstone
- No interest in office payment plan for amounts under \$1,000

### **Insurance**

Our office is committed to helping patients maximize their benefits. Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. As a service to our patients, we will be happy to manage all dental claim submission and follow up on your behalf. If you have any questions, our courteous staff is always available to answer them.

### **Minors**

Payment for services for the treatment of minors can be made by check, cash, or credit card and is the responsibility of the adult accompanying that minor.

### **Missed Appointments**

Once an appointment has been made, that time is reserved specifically for you. Patients who do not show up for an appointment or cancel with less than 24 hours notice are subject to a \$25 late cancel fee.

### **Service Charges**

The policy of this office is to charge 2% interest monthly (24% annual percentage rate) or a billing charge to all accounts over 90 days past due. There will also be a \$25 fee for all returned checks.

### **Collection Fees**

Fees incurred to collect payment will be billed and payable by the patient's account holder.

### **Financial Consent**

The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.

**I understand and agree to this Financial Policy and Agreement**

**X**

\_\_\_\_\_  
Signature of Patient/Responsible Party

**X**

\_\_\_\_\_  
Date