



OUR FINANCIAL AND PAYMENT POLICY

Payment is due at the time services are rendered. For your convenience we do accept cash, check, credit cards (MasterCard, Visa, American Express, Discover) or CareCredit.

CareCredit is subject to credit approval and may be applied for online or we can assist you with this in our office. Availability and rates can change without notice. CareCredit does offer 0% financing, our office covers the interest for you!

Returned check fee is \$25.00. Any balances on account over 30 days will be charged interest of 1.5% per month (18% APR). After 90 days, accounts will be referred to an outside billing or collection agency. There will be a \$50.00 charge for every hour of appointment time cancelled without giving 24 hours notice.

Please circle below the form of payment you choose to settle your account.

- Cash or check
- Credit Card
- CareCredit

ABOUT YOUR DENTAL INSURANCE

As a courtesy, we will be happy to file your dental claim for you when: (1) You have provided us with your **current** dental insurance information. (2) We have received payment of your deductible and estimated co-payment at the time of service. We do not file secondary insurance claims therefore we will be glad to provide you with the necessary information so that you can. Your monthly billing statement will show that insurance has been filed, payment received, and balance due for every procedure. Your statement and insurance company will have the answers to any questions you may have. Please refer to these before calling the office. If you wish for us to investigate any insurance problem, there is a minimum fee of \$15.00 plus \$25.00 per hour.

I understand and agree that (regardless of my insurance status) I am responsible for the balance on my account for services rendered. If the insurance has not paid within 60 days, or if the insurance fails to pay benefits as estimated, I will pay the outstanding balance at that time. My signature acknowledges that I have read and understand all this information and agree to its conditions.

Signature of Patient/Responsible Party

Date