FINANCIAL AND PAYMENT POLICY

Thank you for choosing us to deliver your dental care. We feel that everyone benefits when there is a definitive and clear financial agreement prior to treatment. To make your financial arrangements as easy as possible, we accept the following methods of payment: Cash, Check, Visa, MasterCard, Discover, American Express, or Care Credit.
After being evaluated by the Doctor, you may request an estimate for any procedure charges prior to having treatment.

Please choose one of the following payment options:

_____**Option 1 INSURANCE:** We participate with Delta Dental Premier, Blue Cross Blue Shield Dental, Aetna PPO and Vital Savings, and United Concordia

We ask you to realize that we do NOT work for an insurance company. Rather we work 100% for our patients. We feel that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge WILL ALWAYS BE BASED ON YOUR INDIVIDUAL NEEDS, NOT ON YOUR INSURANCE COVERAGE.

If your insurance covers your procedure, we will submit to participating insurance companies for covered services. If benefits cannot be determined at the appointment time, you will be considered a self-pay patient and payment in full will be due at the appointment time. **We will do a complimentary benefit check, but benefit verification from an insurance company is not a guarantee of payment/coverage.** A traditional insurance plan pays a percentage of treatment up to a certain maximum benefit. **The percentage (co-pay plus any deductible) you are responsible for plus any amount over you yearly maximum will be due and collected the day of treatment.** If your insurance carrier denies payment, or delays payment beyond 60 days a 0.5% finance charge will be applied to your account. We will assist you in understanding your policy but it is your responsibility to know your insurance coverage prior to your appointment.

_____**Option 2: Payment in Full** is due the day of treatment. Self-pay patients (no insurance) with charges over $1,000 who make full payment the day of service by cash or check will receive a 5% courtesy discount.

_____**Option 3: Easy Pay (for patients without insurance coverage)** If you do not have dental insurance coverage , divided payments for any amount (guaranteed by a credit card) can be arranged with half (50%) of the total fee due at the time of service. **The remaining balance will be billed directly to your credit card 30 days from the date of service**

(To be completed by office) Estimated Portion: _____

½ due today: _____ ½ balance to be charged on ___/___/_____

Please fill out the following information

Credit Card: Visa MasterCard Discover AMEX Name on Card: _____

Card No:_____ Exp Date:_____ 3 digit code: _____

Signature of Acceptance:_____ Date:_____

_____**Option 4: CARE CREDIT** is for patients that require payment plans beyond 30 days. Care Credit requires an application and credit approval. Payment is made by you directly to Care Credit. Our office offers either 6,12, or 18 months with 0% APR or extended plans of 24, 36, and 48 months with a minimum balance of $1,000 at 14.9%, and 60 months with a minimum balance of $2,500 at 14.9% APR.

Please choose one of the following and complete the required information:

_____ months with 0% APR
Choose 6, 12, or 18 months

_____ months extended plan with 14.9% APR
Choose 24, 36, 48 or 60 months

Amount to Charge:_____

Name of Card: _____ Card No: _____

Signature of Acceptance: _____ Date: _____

This signature is my agreement to the payment policy as described above. I accept full financial responsibility for all charges incurred. I understand that I will be apprised of my account status every 30 days. For accounts overdue 60 days or more **finance charges will accrue every 30 days at the rate of 0.5% until your overdue balance is paid in full**. I understand that will be responsible for any penalties incurred by an outside institution. **Please note that the person who signs this form is considered the responsible party for this account. Patients under the age of 18 cannot be responsible for their own account.**

Patient's Name:_____ Today's Date: _____

Printed Name:_____ Signature: _____

CANCELLATION POLICY

We understand that emergencies arise and you may not be able to keep your scheduled appointment. Please understand that we reserve time for your treatment. Missing scheduled appointments prevents other patients from receiving treatment, and reduces our options for keeping your dental treatment fees down. We try to be respectful of your time, while at the same time asking you to understand the emergency nature of dental treatment and our mission to be available for your dental emergencies. We ask that you are respectful of our time by **allowing us 2 business days** to reschedule appointments, and by informing us of last minute emergencies that may cause you to miss or be late for a scheduled appointment.

This signature is my agreement with the cancellation policy. I understand that I may be asked to reschedule an appointment if late, and may receive a charge for more than one missed appointment.

Patient's Name:_____ Today's Date: _____

Printed Name:_____ Signature: _____