

PAYMENT POLICY

Welcome! Thank you for selecting us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our payment policy.

**PAYMENT AGREEMENT:**

Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payments may be made using cash, check, Debit Card, Visa, Mastercard, Discover or American Express. A 3% surcharge will be applied to all credit or debit card transactions. To avoid this surcharge, you may pay by check or cash. Checks that are returned to our office from your financial institution are subject to a $30 returned check fee. This fee covers the processing fees that are charged to our office.

We also accept CARECREDIT, which is a 3rd party financing option available only for healthcare expenses. CARECREDIT is a short-term loan for which you can apply online at [www.carecredit.com](http://www.carecredit.com)

**INSURANCE INFORMATION:**

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. In order to do this, we need your insurance card on your first visit of every calendar year (your insurance year may not run January – December). Know when your insurance calendar year begins and ends and provide us with your new card. Please also notify us if your insurance company has changed and if you have secondary insurance through your spouse or parent.

If your dental insurance provider has not reimbursed our office within 90 days of claim submission, you will need to make full payment to our office and be reimbursed when your insurance company pays you. After 90 days the patient is responsible to pursue payment from the insurance company. We can provide all current documentation in order to assist your inquiries. You have a greater ability to deal with the insurance company and your employer who is responsible for the policy.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of our Payment Policy also shall cover your dependent children who may be patients of this practice.

Patient’s name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_