



OUR FINANCIAL ARRANGEMENT

Thank you for choosing us as your dental care provider. It is the intention of all personnel in this office to provide for your dental health needs as thoroughly and as efficiently as possible. Please understand that the payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read, agree to and sign prior to any treatment.

PAYMENT ARRANGEMENTS

There are several methods of payment available. In order that we may have a definite understanding regarding the payments of dental fees, please choose one of the following:

- **CASH PAYMENT PLAN:** Payment of dental services must be paid for at each appointment by cash, personal check, or credit card. All new patients and emergency patients must pay for services as they are performed on the first visit.
- **MONTHLY PAYMENT PLAN:** For amounts over three hundred dollars, we offer financing through Care Credit. After a patient's credit approved, he may repay his loan over a twelve month period with no finance charge added. Of course, the patient is welcome to make their own personal arrangements with their own bank if they wish.

INSURANCE

To avoid disappointment, we strongly suggest that you contact your insurance company to make certain that your dental insurance assumptions are correct. As you know, most insurance companies only pay a portion of the dental investment. We require your estimated insurance portion at the time services are rendered

Further, patients must realize that professional services are rendered to a person, not to an insurance company. Hence the insurance company is responsible to the patient and the patient is responsible to us. We cannot render services on the assumption that the charges will be paid by an insurance company. However, we will help in any way we can.

OVER DUE ACCOUNTS

All accounts with a balance after 60 days will be subject to a finance charge equal to 1.5% per month. If you find you are unable to pay your bill, contact us and we may be able to set up an extended payment plan for you.

If at any time you have questions regarding any treatment, fee or services please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding to rectify and injustice, or to preserve a friendship.

I have read, understand and agree to the above financial plan.

Responsible party _____ Date _____

Comprehensive Family Dental Care...for Life!