

Our Financial Policy

Thank you for choosing our office for your dental needs. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are always available to answer your questions or assist you in any way we can.

All of our fees or co-pays less than \$200 will be due and payable at the time treatment is rendered. We happily accept cash, personal checks, or credit cards (MC, Visa, American Express and Discover).

For our patients with dental insurance: We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. The insurance relationship constitutes an agreement between the carrier and the patient. As such, we can make no guarantee of estimated coverage or payment. Please know that we will do everything possible to see that you receive the full benefits of your policy.

Payment Options

1. Pre-payment Courtesy:

We are happy to offer a 5% accounting courtesy for all treatment over \$400 that is paid in full prior to treatment commencing.

2. Payment As Services Are Rendered:

If you wish to pay the estimated amount for treatment not covered by insurance at the time services are rendered we gladly accept cash, personal checks and most major credit cards.

3. Monthly Payment Plans:

"Same As Cash" Interest-Free Credit Line

Monthly payments (up to 12 months) interest-free.

Extended Payment Plan

For treatment plans between \$1500 and \$25,000.

18-60 months duration.

No down payment required.

Payments as low as \$75 / month.

No pre-payment penalty.

3 Equal Monthly Payments

25% initial down payment.

Guaranteed with major credit card.

"Lay-Away" Plan

Treatment commences after comfortable monthly payments are made which equal estimated patient portion.

Discounted Amount Adjusted Total

Monthly Total

Range: to

Down Payment 3 Monthly Payments

I, _____, understand that any insurance coverage estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office. Any insurance claim not paid in full after 60 days will become my responsibility to pay at that time.

Patient (or Responsible Party) Signature: _____ Date: _____

Financial Coordinator Signature: _____ Date: _____