FINANCIAL POLICY

Our practice is dedicated to providing the best quality care for you. As a courtesy to our patients who have dental insurance, we participate in third party billing (we will file electronic claims to your insurance company through an insurance clearing house). However, whether you have insurance or not, by signing this policy you are agreeing to pay for all services that are received.

Insurance Participation: We participate with several insurance companies and agree to their fee schedules. However, if your insurance is not one we participate with, or our level of agreement of participation is different then what your insurance has offered you, you as the patient are responsible for the difference in fees.

Payment Options: We will request your payment or your copayment at time of service.

A. We accept cash, check, debit card, VISA, Mastercard, Discover and American Express, along with HSA and Flex Spending cards.

B. For larger procedures (including multiple visit procedures) we will accept 50% of the amount owed by you at the start of the procedure and require the remainder when your procedure is completed.

C. We offer financing through CareCredit (interest free promotional periods) and Lending Club Patient Solutions (low-interest rate plans) for larger balances. CareCredit can also be accepted for all balances, but if the balance is under $200 we are not able to offer an interest free period. Please speak to the financial coordinator for all terms and conditions of both plans.

If you have a balance on your account, we will send you a monthly statement. The balance is due within 30 days after the issue of your statement. It will be considered past due if not paid by the date stated on your statement.

Finance Charge: A finance charge will be imposed on your account that has not been paid in full within thirty (30) days of the time the item was added to your account. The FINANCE CHARGE will be computed at the rate of one and one half percent (1.5%) per month or an annual rate of eighteen (18%) percent. The finance charge on your account is computed by applying the periodic rate (1.5%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed from the previous 30 days and then subtracting any payments or credits applied to the account during that time.

Discounts: Patients not covered by insurance are eligible for a 5% discount when payment is received at time of service. This does not apply to patients using CareCredit or Lending Club Patient Solutions.

Senior Citizen Discounts: Patients 65 or older receive a 10% discount.

Returned Checks: We charge $25 per check for any checks returned by the bank.

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Missed Appointment Fee: We charged a missed appointment fee of $50 for appointments that are cancelled with less than 24 hours' notice or for patients that are more than 20 minutes late for their appointment. We reserve the right to waive the fee.

Past Due Accounts: If your account is 90 days past due, we will inform you that your account will be sent to a collection agency. If this situation arises, you will be responsible for any collection costs that are incurred. Our current collection agency is Capital Accounts, LLC. Please be aware that if your account is submitted to this collection agency, record of your treatment may become a matter of public record.

Divorce: In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the child will the parent who is fiscally responsible for any balance incurred. If the divorce decree requires the other parent to be responsible for a portion of said balance, we will not be responsible to do so. It is the authorizing parent's responsibility to be reimbursed.

Transferring of Records: Please request the transfer of your records in written form. Email is acceptable. Please know we may receive or transfer your payment history as well.

This financial agreement comes into effect on the date of signature.

Patient's Name:_____

Responsible Party (or Legal Guardian)_____

Signature:_____**Date:**_____