FINANCIAL POLICY

Our office wants all of our patients to be able to comfortably afford dental care. We proudly offer the following policy so that you can have the opportunity to decide which payment option best suits your needs.

Insurance:
Our office understands the value of insurance benefits to our patients and will gladly work with you to help get the maximum benefit available to you. We will estimate your deductible and the portion that is covered by your insurance carrier. The amount that we have determined not to be covered by the carrier is due at the time of treatment and may be paid by any of the options listed below. Our estimates are subject to final approval by your insurance company and could therefore change the amount due to our office.

Payment Options:

1. Credit Cards- Our office accepts American Express, Discover, Visa, or MasterCard.
2. CareCredit – Interest free financing for 6-12 months and standard terms up to 5 years upon credit approval.
3. Lending Point – Standard terms financing up to 5 years upon credit approval.

There is a $25 fee for all returned checks. Balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

Due to the popularity of our state-of-the art dental office our appointment times are extremely important. Our time, as well as our patients' time is respected. Therefore, we may charge $45/hour scheduled for appointments canceled or broken without 48-hour advance notice. After 3 missed or broken appointments you may be asked to find another healthcare provider for your dental needs.

We would be happy to work with you to plan out the most appropriate arrangements for your lifestyle. Financing your treatment allows you to start your dental care immediately and spread the payments over a period of time. Most importantly, it offers you the opportunity to enjoy the benefits of your dental health without the financial strain. We are committed to providing you with the most positive experience in dental care.

Patient/Responsible Party Signature:
_____ Date _____

Patient Name or
Names:_____