



### **Financial Policy**

Our office wants all our patients to be able to comfortably afford dental care. We will gladly discuss our payment options with you before beginning your treatment. We proudly offer the following financial policies so that our patients can have the opportunity to decide which payment option best suits your needs:

**Dental Insurance:** Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be asked to pay your deductible and your co-payment for the charges on the day the service is rendered. We are happy to file the forms necessary to assure you receive the full benefit of your dental insurance. We'll gladly estimate your coverage; however, many variables exist from carrier to carrier (i.e. deductibles, annual maximums, allowable fee limitations, non-coverage procedures and other restriction). Therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their portion within 60 days from the start of your treatment, you are responsible for payment at that time. **Also for all treatment under \$100.00, excluding preventative treatment, you will be asked to pay in full.**

### **Payment Options:**

1. **Prepayment option:** We are happy to offer a **5% pre-payment courtesy for all treatment paid in full with cash or a check before the date of treatment.**
2. **Cash or check:** On the date of service
3. **Credit Card:** Our office accepts VISA, MasterCard and, Discover on the date of service.
4. **Outside Financing** For treatment over \$300
  - Care Credit
  - Spring Stone
5. **Senior Citizen Discount:** As a courtesy to anyone 60 years or older, we will gladly discount your fee by **10% if services are paid at the time of treatment.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_