# Financial Policy

**Patient Name:_____Date:_____**

**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 and/or assist you in any way we can.**

**Fees and co-pays are due and payable at the time treatment is rendered. We accept cash, personal checks, or credit cards (MC & Visa).**

**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 the estimated coverage or payment. However, please know that we will do everything within reason to see that you receive the full benefits of your policy.**

## Payment Options

- ***Prepayment Courtesy:***

  **We are happy to offer a 5% accounting courtesy for all treatment over $500.00 that is paid in full by check or cash prior to treatment commencing.**

* ***Payment as Services are Rendered :***

**When paying the estimate amount for treatment at the time services are rendered, we gladly accept cash, personal checks, and most major credit cards. Because we cannot guarantee your exact insurance coverage, there may be a balance remaining after insurance payment is received. Should you wish, you may leave a credit card on file for any balance that may be owed.**

- ***Monthly Payment Plans*:**
- **"Same as Cash" Interest-free Credit Line**
  **Monthly payment (up to 12 Months) interest free. This option is offered through Care Credit Financial. Credit application required.**

***3 Equal Monthly Payments***

**3 equal payments guaranteed with a major credit card. (Signed contract required).**

**"Lay-Away" Plan**

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

**I,_____, understand that any insurance 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.**

**Signature:_____**