

Financial Information

“In God We Trust – All Others Must Pay Cash”

1. We can be *GOOD*, we can be *FAST* or we can be *CHEAP* – but unfortunately, not all at the same time. Our fees for professional dental services are a reflection of the time, staff, materials, equipment, and current expertise involved in providing you with the very best quality and most personalized dental care possible. We strive to make good dental health affordable for all of our clientele while maintaining a practice that will be here to serve you and our community for many, many years.
2. All major treatment and treatment involving outside laboratory expenses will require a down payment of 1/2 of the total balance before treatment begins, with the total balance paid before any crown or denture is completed.
3. In the case of minor children, the parent or legal guardian authorizing treatment for the child is financially responsible to this office, *regardless of any separation, divorce or court agreements*. We are not a party to these agreements.
4. **Unpaid balances over 30 days will be assessed a 1.5% late charge.** All outstanding balances over 90 days *without prior arrangements* will be subject to collection by an outside agency, which may incur additional fees and adversely affect your credit rating.
5. Returned checks will be assessed a \$35.00 charge to cover bank fees incurred as a result.
6. **We understand that unexpected circumstances can sometimes delay financial obligations. Please contact our office manager immediately to make satisfactory payment arrangements. When communication and good faith exists, we can work it out.**
7. If you have dental insurance, we will help you to determine the benefit that you have available and how it applies to your dental treatment. However, your dental insurance policy is a contract negotiated between you, your employer and your insurance company *only*. We are not a party to that contract.
8. Not all dental insurance plans are created equally. Dental benefit plans vary widely between different insurance companies. Additionally, an insurance company may offer multiple dental benefit plans. And lastly, employees at the same company may receive different levels of benefits based on their job position or years of employment. All recommended dental services may *not* be covered by the plan chosen by you and/or your employer. Please be aware of your plans specific benefits and limitations, and how they may apply to your recommended dental treatment plan.
9. Payment for all services rendered is the financial responsibility of the patient *regardless* of any insurance involved.

We strive to offer convenient payment plan options while at the same time maintaining the high standard of comprehensive dental care that our patients deserve. Before we begin your treatment, we will provide you with an estimate of your total treatment costs. Our goal is to help you afford your dental choices. Please review the next page for Payment Options available.

Payment Options

We request that all new patients pay in full at time of service for the first initial visit to our office. The Payment Options below are then available for each subsequent visit.

Plan A: Payment in full, via Cash, Check or Credit Card, on the day of each visit.

To show our appreciation for patients who pay in full, via cash or check, at time of service, we will extend a five percent (5%) courtesy fee reduction.

To show our appreciation for patients who pay in full, via Credit or Debit Card, at the time of service, we will extend a three percent (3%) courtesy fee reduction. We gladly accept MasterCard or Visa.

*Note: As a courtesy, we are happy to bill your dental plan for completed services and you will be reimbursed directly.

**Note: You may opt to have your courtesy adjustment donated to the Juvenile Diabetes Research Foundation and our office will match your donation 100%. Please ask us for additional information.

Plan B: Use Medicaid, Child Health Plus or Family Health Plus benefits.

Our office will file your Medicaid, Child Health Plus or Family Health Plus claims. You are responsible to ensure your eligibility on the date of service. You will be financially responsible for any dental services accepted while ineligible. If a recommended or elective dental procedure is denied through your insurance program you may still choose to have the treatment completed; however, you will be personally responsible for payment at time of service.

Plan C: Maximize dental insurance benefits, paying 20% Co-Pay at time of service.

*Note: Not available to Delta Dental, GHI or Blue Cross Blue Shield policy holders, insurance reimburses subscriber directly.

As a courtesy, we are happy to bill your dental plan for completed services. Please remember that your dental benefits contract is between you, your employer, and your insurance carrier. Regardless of coverage, we *estimate* a 20% co-pay due at time of service. If your dental plan does not pay within 60 days of treatment, you must pay outstanding balance and seek reimbursement from the insurance carrier. If your dental plan pays more than expected, you will receive a refund check.

Plan D: Maximize dental insurance benefits, no Co-Pay, charge Credit Card upon payment.

*Note: Not available to Delta Dental, GHI or Blue Cross Blue Shield policy holders, insurance reimburses subscriber directly.

As a courtesy, we are happy to bill your dental plan for completed services. Please remember that your dental benefits contract is between you, your employer, and your insurance carrier. *Upon receiving payment from insurance carrier, our office will charge your credit card any remaining balance from the claim.* Credit card numbers will be kept confidential.

MasterCard/Visa Number: _____

Expiration Date: _____ Signature Code: _____ (3 digits on back)

Please contact our office if you have any questions regarding the payment options described above.

I, _____, have chosen Plan _____ (above) and accept full financial responsibility for this account and for all dentistry performed upon my dependents in this dental office. I have read both pages of the financial information for this office. I understand that it is my responsibility to confirm my insurance eligibility and benefits. I know that any insurance estimate or information given to me by this office is not a guarantee of actual insurance payment. I also understand that any insurance claim not paid in full after 60 days will become my responsibility to pay.

Patient Signature: _____

Date: _____