Dat Complete Dentistry Patient Financial Policy

Welcome to our office! We are honored that you have chosen us as your dental provider and look forward to working with you. Our practice is committed to providing an excellent dental care experience to you and your family and has implemented the financial policies outlined below to assist in that regard. These financial policies are followed by our practice so that we can stay focused on what we do best – providing you with personalized, comprehensive dental care services. Thank you in advance for your cooperation.

1. **Payment for all treatment is due at the time services are rendered unless other written payment arrangements have been made with our team in advance.**

2. **Payment for services may be made by cash, check, or credit card. We accept Visa, MasterCard, Discover and American Express. There will be a 3% surcharge for the credit card processing fee automatically added to your credit card.**

3. **We are pleased to offer financing through Care Credit. Those who qualify will use Care Credit as a form of payment at the time of service. Care Credit will have pre-approved of the patient and set up a monthly payment plan. This program is similar to a credit card and offers low monthly payments and flexibility to those who qualify, offered on an interest-free basis.**

4. **If you fail to show for a scheduled appointment or cancel and appointment with less that 24 hours advanced notice, the practice reserves the right to charge you a fee for such broken or late-changed appointment. The fee for broken appointments is $50 per appointment.**

5. **As a courtesy to our patients with dental benefits, we will submit your claims to your insurance company. Your insurance coverage is a contract between you, your employer and the insurance company – not your insurance company and us. It is your responsibility to familiarize yourself with your insurance coverage. Any portion not expected to be covered by these benefits is the responsibility of the patient and is due at the time dental treatment is performed. This amount will include deductibles and co-payments. Please understand that this is only an estimate – not a guarantee of payment and is based on the information available to us from your insurance company. Any insurance bill not settled within 60 days will be due in full and your responsibility to pay. Please be aware that some and perhaps all the services provided may be non-covered service.**

6. **If services are not paid for at the time services are delivered, you will be provided a statement for the amount due and will be expected to pay that amount in full promptly following receipt of the statement. Accounts unpaid after 60 days from the day or service are subject to a delinquent fee of $35. Furthermore, there is a $35 fee for any returned check. If the amount due is not paid in full within 60 days from the day services are delivered to you, the practice may refer the collection of the unpaid amount to a collection agency or collection attorney. If we must submit your unpaid account to a collections process, you will be responsible for all charges our practice incurs – including court costs and reasonable attorney's fees.**

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

Patient Name: _____

Patient Signature: _____

Date: _____