

## DENTAL ART FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We offer quality dental services to our patients in a caring and gentle environment. To help you achieve optimum dental care and make it financially comfortable, our office offers various payment options. Our patients appreciate knowing approximately what financial responsibilities they would incur for their dental treatment. Therefore, we inform our patients about our financial policies and options before we begin any treatment. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

1. **Full payment is due at the time of treatment**, unless other financial arrangements have been made with our office.
2. **Payment method:** Payment is accepted by Cash, Visa, MasterCard, ATM/Debit Card with Visa or MC logo.
3. **We do not accept checks as a form of payment.**
4. **Payment Responsibilities of minor patients:** Adults accompanying minor patients are responsible for full payment at the time of treatment, unless other arrangements are made with our office prior to treatment. For unaccompanied minors, charges will have to be pre-paid by cash or credit card.
5. **Missed Appointments:** If it becomes necessary to cancel a scheduled appointment, please inform us ASAP, but at least 48 hours in advance. This would avoid applying cancellation charges to your account, and also enables us to offer the time previously reserved for you to another patient. Cancellation fee is \$75 for 1/2hr to 1 hr appointment and \$150 for 1½ hr or longer appointment.
6. **Dental Insurance. If you have dental insurance please read the following facts carefully.**
  - a) **Dental Insurance is a contract between you and your insurance company.**
  - b) As a courtesy to you, we will be glad to file your treatment with your insurance company.
  - c) Please be aware that we are only capable of **estimating** your portion of payment based on the benefit information that we receive from your Insurance Company.
  - d) **Most Insurance companies will not cover 100% of all dental expenses.** It will be your responsibility to pay the deductibles, co-pay or any other balance that is not paid for by your Insurance Company.
  - e) Insurance companies may try to dictate treatment by considering some services to be unreasonable, unnecessary or cosmetic. In any event, you as a patient will be responsible for all the charges for the services provided at our office, which may not be paid for by your Insurance Company.
  - f) **Our practice is committed to providing the best treatment for our patients.** We charge what is usual and customary based on services provided in our area. You are responsible for any charges, regardless of the Insurance Company's arbitrary determination of usual and customary rates. If you have a PPO with which our office participates, we will NOT charge more than the maximum allowed by the PPO fee schedule.
7. **Payment by appointment:** For larger treatments, we can divide the total treatment cost by the number of total appointments. This will enable you to pay for your treatment in smaller installments, thereby allowing you to manage your personal finances efficiently while receiving the needed dental treatment.
8. **Pre-Pay discount:** A 5% discount will be given to treatment plans over \$1,500 if the entire payment is made at the beginning of treatment. (Some restrictions apply, please ask for details)
9. **Care Credit:** Our office offers **Interest free** as well as **low monthly payment** plans...please ask for details.
10. **Collections Policy:** Any fees incurred in an attempt to collect an outstanding balance will be paid by you the patient. Should litigation ever become necessary you the patient will agree to pay all court costs and attorney fees. Should the account become over 30 days past due a finance charge of 1.5% or \$5, whichever is greater, per month will apply to the outstanding balance. There is also a \$30 processing fee for each returned check.

**I have read, understood and agree to this financial policy presented by Neil Shusterman D.D.S. d.b.a. Dental Art**

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(Print Name)

(Signature of patient/responsible party)

(Date)

**Thank you for reviewing and acknowledging our financial policy. Please let us know if you have any questions or concerns regarding this policy.**