Financial Information and Options

The following information will give you methods of payment accepted and the monthly payment plan option we have available.

Methods of Payment

1. Cash
2. Check (processed electronically)
3. Debit or credit card (Visa, MasterCard, Discover and American Express).
4. Monthly payment plan (see below).

Monthly Payment Plan

Through a company called **Care Credit®** we are able to offer a monthly payment option to our patients. The plan offers ***no-interest*** options, as well as long-term low interest rate plans. It is a great benefit for those patients without dental insurance, but also works well in conjunction with dental insurance. Once qualified, there would be no out-of-pocket payment due at the time of the appointment. Our finance office can assist you with setting up a credit line in a matter of minutes.

Dental Insurance

For patients with dental insurance – as a courtesy we will send in your claims for payment to us with your understanding that your policy is a contract between you and your insurance company and you are responsible for any charges incurred from services rendered. Your insurance plan is only a method of payment not a method of treatment. We will ask you for your ***estimated*** co-pay using the detailed information your insurance company provided to us. If we don't receive any reimbursement or any reason for denial within 30 days, we will resubmit the claim ***once***. We will wait two more weeks and if there is still no response or payment, the remaining balance will become your responsibility to pay. If you have paid the balance and then the insurance company sends the check to us, we will immediately send that amount to you (or you may keep it as a credit on your account for more treatment). For your convenience, we can keep a credit card on file or you can use your Care Credit® account to take care of any balance the insurance company doesn't cover.

Broken Appointment Fee

We hope you understand that when we make an appointment for you, that time is specifically set aside just for you. We do understand that emergencies arise, and we are flexible in those matters. However, a "forgotten" appointment or last minute cancellation (under 24 hours), whether confirmed or not, is subject to a $65 broken appointment charge. For multiple family appointments on the same day, the $65 charge is for each missed appointment that day.

I have read and understand the above information. I understand I am ultimately responsible for all charges incurred from services rendered. I affirm that the information I have given today is correct to the best of my knowledge and I understand this information, and any changes I relay to the office staff, will be held in the strictest confidence.

Name of Responsible Party (please print)_____

Signature_____ Date_____

(OVER PLEASE)

Account, Appointment and Insurance Information

Today's Date:_____

PERSON RESPONSIBLE FOR ACCOUNT (If different than patient):

Name_____Date of Birth ____/____/____ (S __ M __ W __)

SSN_____-_____-_____ Driver's License # _____ State _____

Home Address _____ City_____ State_____ Zip_____

Mailing Address (if different)_____ City_____ State_____ Zip_____

Home Ph( )_____Wk Ph( )_____ Cell Ph( )_____

APPOINTMENT NOTIFICATION

How do you prefer to be notified regarding your appointments? Please list the phone number or email address you access the most often on a daily basis.

☐ Phone (_____)_____ x_____ Best time to call_____

☐ Email _____@_____ (will not be sold or given out)

PRIMARY DENTAL INSURANCE:

Member's Name_____ Birthdate_____/_____/_____

Relation to Pt_____

Member's Employer_____ Member's SSN____-____-_____

Insurance Co. Name_____ OR

Insurance Phone Number (_____)_____ Member's ID #_____

Mailing Address for Dental Claims_____ Group #_____

City_____ St_____ Zip_____

SECONDARY DENTAL INSURANCE:

Member's Name_____ Birthdate_____/_____/_____

Relation to Pt_____

Member's Employer_____ Member's SSN____-____-_____

Insurance Co. Name_____ OR

Insurance Phone Number (_____)_____ Member's ID #_____

Mailing Address for Dental Claims_____ Group #_____

City_____ St_____ Zip_____

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