



AVALON DENTAL
Bradley P. Dilling, DMD

Bradley P. Dilling, D.M.D.
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Fort Myers, Florida 33919
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FINANCIAL POLICIES AND SIGNATURE ON FILE AGREEMENT

Payment is Due at Time of Service

Insurance: Your dental insurance is your responsibility. The insured or the guarantor is responsible for the total treatment fees. As a courtesy to you, we will file your claim and after dental insurance has paid, a statement is mailed to the address on record if a remaining balance exists. Payment of the remaining balance is expected within 15 days of the statement. If your insurance company does not pay the claim within 45 days, it will be your responsibility to pay the outstanding balance.

Reimbursement by your insurance company is dictated by a contract between your employer and the insurance company. We are not a party to any of those contracts.

Tender: Cash, personal checks, Visa, Mastercard, Discover and American express accepted. Optional financing is available through Care Credit with a processing fee added to balance. (www.carecredit.com). Please be advised that returned checks will be subject to a service charge.

Overdue Balances: Accounts with an unpaid balance past 120 days will be sent to a collection agency. At that time, you will be responsible for any and all cost incurred in the collection of your debt.

Broken Appointments: Appointments not kept or rescheduled, with less than 48 hours notice are considered broken appointments. Broken appointments prevent others from receiving the dental care they deserve. Please be considerate and inform us in advance if you need to reschedule your appointment. We reserve the right to charge \$50.00 for broken appointments.

Payment is Due at Time of Service: Dr. Dilling understands temporary financial problems may affect timely payment of your balance. In those situations, we encourage you to communicate any such problems immediately so that we may assist you in the management of your account.

Consent & Authorization: I agree to pay all related fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understand this document, outlining financial policies of Bradley Dilling, DMD, PA. I agree to abide by the policies outlined herein.

Patient Signature _____

Date _____