

## PAYMENT OPTIONS WITH NO INSURANCE BENEFITS

Payment in full is due at each appointment, (cash, check, Mastercard, Visa or Discover) you will receive a 5% courtesy.

We offer up to 12 months, 0% interest free financing available with credit approval.

A service charge of 1.5% per month or 18% per year is applied to all balances that exceed 90 days.

## PAYMENT OPTIONS WITH INSURANCE BENEFITS

Your estimated portion is due at the time of service with a 5% courtesy on all dental work over \$200.00. **Payment in full is then due once insurance had paid their portion.**

I understand that I am financially responsible for all charges whether or not paid by insurance. After insurance benefits have been paid, the remaining balance will need to be paid in full within 30 days of receiving your Explanation of Benefits.

Orthodontic patients require a down payment and monthly payments set by the treating doctor.

*"I have read and I understand the above stated financial policy."*

Patient/Guardians Signature: \_\_\_\_\_ Date \_\_\_\_\_

*Please read and sign the following as required by your dental insurance company:*

I authorize release of any information relating to this claim

I authorize release of any information relating to this claim

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify) \_\_\_\_\_