

PAYMENT POLICY ACKNOWLEDGEMENT

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. In order to achieve these goals we need your assistance and your understanding of our payment policy. For the convenience of our patient we offer the following methods of payment.

- A. Payment in full by cash, check, bankcard, or Care Credit for each appointment as service is rendered. A courtesy is offered on fees over \$500 if paid at the initial appointment.
- B. Bank charge cards – Visa, MasterCard, American Express or Discover
- C. **Care Credit** accounts are gladly accepted. We will assist you in filling out an application, or you may do so online before you come in.
- D. Major services: Appliances, crowns, bridges. Payment in full at initial visit with courtesy, payment of 1/2 at the initial appointment and 1/2 upon completion. Crowns, Partial and dentures must be paid in full **before** delivery.
- E. We are not a Medicaid / Prime Care Provider.

Please be aware that any parent bringing a child to our office is legally responsible for payment of all services rendered.

If you have dental insurance, we are happy to help you receive your maximum allowable benefits. It is important that you realize, however that..

- 1. Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract.
- 2. Some dental services are not a covered benefit in your contract.
- 3. You, (not the insurance company), are responsible to us for all of our fees for services.

We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care. We appreciate the opportunity to serve you.

_____ Date _____
 Patient or responsible party signature

Credit Card Payment Authorization: (Valid until further notice)

Patient Name: _____
 I authorize the office of **Dr. Andy Friedman DMD** to keep my signature on file for any charges not paid by my insurance within 90 days and charge my credit card account.
 ___Discover ___Master Card ___Visa ___American Express ___ Care Credit
 Account # _____ Expiration Date: _____
 Card Member Name/Signature: _____ Date _____