

Dr.'s Paul and Kathy Helsby
2100 Aloma Ave, Ste. 200
Winter Park, FL 32792
407-678-1601

Dental Financial Policy and Agreement

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care. Our convenient financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities.

Payment

Payment in full is due at the time of service unless prior financial arrangements are made. We offer several payment options:

- _ Cash, Checks, Visa, MasterCard, Discover and American Express
- _ Pre-payment discounts
- _ Monthly payment plans in accordance with the office credit guidelines

Insurance

Our office is committed to helping patients maximize their benefits. Because insurance policies vary greatly, we can **estimate your coverage in good faith**, but **cannot guarantee it**. As a service to our patients, we will be happy to manage all claim submission and follow up on your behalf. If there is a difference in dollar amount due, a statement will be sent to you and is due upon receipt.

Minors

Payment for services for the treatment of minors can be made by check, cash or credit card and is the responsibility of the adult accompanying that minor.

Missed/Canceled Appointments

Once an appointment has been made, that time is reserved specifically for you. We reserve the right to charge a fee (\$30) for all canceled or missed appointments without 24-hours notice (this includes cancellations for Monday appointments that require 24-hours notice in advance on Thursday). Also we reserve the right to charge a fee (\$60) for all canceled or missed 7 a.m. appointments since these are considered premier appointments specifically for you.

Service Charges

The policy of this office is to charge 1% interest monthly (12% annual percentage rate) or a billing charge to all accounts over 90 days past due. There will also be a \$40.00 fee for returned checks.

Collection Fees

Fees incurred to collect payment will be billed to and payable by the patient's account holder.

Financial Consent

The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.

Responsible Party

The responsible party (the insurance policy holder) is responsible for the financial agreement listed above for all patients (subscribers) under the said insurance policy.

I understand and agree to this Financial Policy and Agreement

Signature of Patient/Responsible Party

Print Name of Patient/Responsible Party

Date: _____