FOREVER SMILES

Shawn D. Knorr, D.D.S • Chris Ibberson, D.D.S

PAYMENT OPTIONS & PATIENT FINANCES

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide payment options to help you receive the dental care you need, which will allow you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care.

PAYMENT OPTIONS

- Cash payment in full at time of service (without insurance reimbursement or other discounts) will receive a **5% discount.**
- Credit Card payment in full at time of service (w/o insurance reimbursement or other discounts) will receive a **3% discount.**
- Care Credit (see brochure for available plans, including 6 mo. & 1 year interest free financing, minimum qualifying balances apply, please ask for more details)
- An in-house office payment plan (involves signing a contract and making arrangements with our office financial coordinator). *A payment plan can only be offered once a credit history is established. In-house payment plans do not span out over 6 months.

STATEMENTS

- Statements will be sent out on any account with a balance >$3.00.
- Accounts with insurance claims outstanding will have an estimated payment due, you will receive another statement once insurance has paid letting you know your actual patient portion due.
- Statements are sent out on the 28th of each month.

INSURANCE PATIENTS

- As a courtesy we will process your insurance claim for you; however, any insurance coverage information is an estimate that is subject to change based on any restrictions and/or imitations established by the dental plan.
- Estimated Patient Portion is due time of service.

FINANCIAL POLICIES

- I agree to be responsible for payment in full, regardless of insurance coverage.
- I understand there will be **$15 late fee** on all accounts that have not posted a payment in a consecutive **60 day period.** Fees will incur monthly with each statement until a payment is made toward the account.
- I understand that if I do not pay on my account on a regular basis and it is turned over to a collection agency or attorney, I agree to pay costs of collections, including attorney or collection agency fees.
- $30.00 fee for any returned checks.

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits to the insurance company for services rendered, or to be rendered, without obtaining my signature on each and every claim submitted for myself and/or my dependents and that I will be bound by this signature as though I had personally signed the particular claim. I understand that I am responsible for all non-covered services after my claim has processed. I further authorize payment directly to the doctor for insurance benefits to which I am entitled.

Responsible Party Signature _____ **Date** _____