Welcome to our practice:

**Your dental care is our major concern. It is our policy to help you plan your treatment to achieve your best dental health.**
The following options are provided for your convenience. Please choose the one that best fits your needs.

**Emergency Care and First Appointments:**
Full payment is required at the time service is rendered. If you have insurance coverage, payment for this visit is required, but our office will arrange for your insurance company to send payment directly to you regarding this treatment.

**Insurance Welcomed:**
We are happy to help you with your insurance. We process your forms, make inquiries to your insurance company about your coverage and benefits and often wait 4-6 weeks after your treatment is completed for the insurance to pay their portion. Please keep in mind we provide these services to help you utilize your insurance benefit. **However, your deductible and or Co-Payment of 30 to 50% is due and payable at each visit instead of full payment for services rendered.**

**Patients Without Insurance:**
If you are not covered by insurance, our fees are due and payable at the time services are rendered. We accept cash, check ( with proper identification) for the exact amount of the treatment and credit cards ( VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS ).

**Cancelled or Failed Appointments:**
*There will be a $50.00 cancellation fee for any appointment failed or cancelled without 24 hours prior notice. Each NSF check is subjected to a $50.00 service charge.*

**PLEASE INDICATE HOW YOU WISH TO HANDLE YOUR ACCOUNT.**

____ a) **PAYMENT AS SERVICE IS RENDERED**
(Cash, check with ID, credit card. )

____ b) **INSURANCE PAYMENT**
(Payment of 30% to 50% is due and payable at each visit and pay balance by cash, check with ID, credit card. )

_____ c) **CARE CREDIT FINANCING**
(Financial monthly payment plans of 6, 12 or more months for treatments over 1000.00 dollars. )

**There is a finance charge of 1.75% per month (21% per year) on unpaid balances over 30 days .**

**There will be a $50.00 charge for all NSF checks.**

| **Patient name**(Please print) **/ Date** | **Patient's Signature / Date** |
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