www.ContemporaryFamilyDentistry.com

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Better health through dentistry.

Financial Policy for Our Office

Our goal is to provide the finest and most comprehensive dentistry services available today. We recommend the best treatment for our patients, and inform you of any options. We are aware that health care costs can significantly impact your budget and want to make our services as affordable as possible. The following are your options for payment of service.

CASH/CHECK/VISA/MASTERCARD/AMERICAN EXPRESS:

- **Payment due in full** at the time of treatment.
- CASH or CHECK payments receive a 5% discount when payment is received in full at the time of treatment.
- VISA, MASTERCARD or AMERICAN EXPRESS payments receive a 3% discount when payment is received in full at the time of treatment.

INSURANCE PLANS:

- Payment of your **estimated** percentage is due at the time of treatment. If there is a difference between what the insurance pays and the **estimate** we collected the balance is due upon receipt of your account statement.
- Insurance is gladly billed as a courtesy to our patients, when you provide us with current information and any necessary forms.
- **All charges** are your responsibility whether or not they are covered by insurance. Insurance reimbursement is between you, your employer and the insurance carrier. Benefits provided are not a guarantee of payment. All patients are advised to contact their insurance for benefit and payment information.

PAYMENT PLANS:

CareCredit and Citi Health Card Payment Plans:

- 3 months, 6 months and 12 months no interest plans
- Monthly installment payment option
- Upon approval, amount financed determines interest free period.
- Minimum monthly payment start at $10.00
- Brochure available, for more information, go to: www.carecredit.com

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits. Accounts assigned to collections will be charged a $50.00 collection fee. All balances over 60 days old will bear interest of 18% per annum or 1.5% per month.

SIGNATURE______________________________________ **DATE**____________