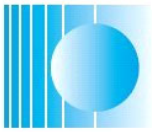

FINANCIAL POLICY & CREDIT CARD AUTHORIZATION FORM

Thank you for choosing our office. Our primary mission is to deliver the best and most comprehensive dental care available. Our fees are based on the quality materials we use and the time, effort and skill required in performing your treatment. They are reasonable and customary to our area.

An important part of the mission is making the costs of optimal care as easy and manageable for our patients as possible by offering payment options. We accept Cash, Check, Visa, MasterCard, American Express or Discover Card. For extensive cases/treatment over $1000.00 we offer usage of a convenient Monthly Payment Option from CareCredit Healthcare Credit Card. This option allows you to pay over time with no annual fees or pre-payment penalties. Payment is due at the time services are rendered unless alternate arrangements have been made in advance with the Practice Manager.

We do not work with HMO, DHMO, Managed Care or state/federally funded dental insurances. For patients with PPO dental insurances, as an **out of network** provider with all plans except for Delta Dental which we are **in network** with, we are happy to work with your carrier to maximize your benefit and directly bill them electronically for costs of your treatment. Your estimated copayments are due on the date of service. While most PPO dental insurances do directly reimburse the dentist, some may only remit payment to the patient. In this case, the patient is responsible for providing payment in full to the office on the date of service and we will file a claim on your behalf to your carrier for partial reimbursement. Most insurances pay similarly with PPO plans for both in and out of network providers.

Once we receive payment from your dental insurance carrier, if there is any balance remaining aside from the estimated copay we have likely already collected, we will notify you by phone or mail. Should any balance remain unpaid after 60 days or should you violate the terms of your payment agreement, we reserve the right to refer your account to our collection agency and your account will begin to incur a 1.5% finance charge per month. Any fees associated with the collection of these delinquent accounts will be the direct responsibility of the patient.

Should you need to cancel/ reschedule an appointment, kindly give the office at least 24 business hours notice (48-72 hours notice for an appointment length of two hours or greater) or a cancellation fee of $75.00 or more, depending on length of appointment, may be applied to your account. If you have not confirmed your appointment, this counts as a broken/missed appointment. There will be a $35.00 fee for any returned checks.

Patient Signature: **Date:**

CREDIT CARD ON FILE OPTION:

For your convenience, if you would like us to keep a credit card on file for balances, you may enter the card information below. **NOTE: We do not wait for a verbal, text or email approval, as this form serves as the authorization.**
Upon any credit card charges processed, please send me a courtesy notification by:
(CHECK ONE) _____ Phone _____ E-Mail _____Mailed Receipt _____ No receipt

Patient Name: _____

Cardholder Name: _____ Relationship: _____

Billing Address: _____

Card #: _____ Exp Date: _____/_____ Sec Code: _____

Cardholder Signature: _____ Date: ____/____/_____

Should this card be used for all family members? _____YES _____NO