FINANCIAL POLICY

Welcome to Design Dentistry. We're glad you've chosen us to provide your dental care. We appreciate the opportunity to serve you. It is our intention to provide you with the finest care possible while ensuring that you fully understand procedures, treatment and payment expectations. Hopefully the following will explain our office financial policy. If not, please ask our Receptionist or Office Manager to clarify any questions you may have.

DENTAL INSURANCE: We need your help with your dental benefits. Please keep records of your maximums and any outstanding claims. As a provider we have no rights with your insurance company but you do. We will be happy to discuss your proposed treatment and any questions you may have about your insurance, plus as courtesy we will bill the insurance for you. Employers constantly renegotiate contracts that change your benefits. We are not given total disclosure of all exclusions. Please bring your benefit booklet with you or contact your human resources department or insurance company if you have questions. Initial_____

Please be aware that, in most cases, your insurance will cover only a portion of the fee for your treatment and you are financially responsible for any amounts not covered. We expect payment of your estimated portion of treatment that insurance does not pay at the time of your appointment.

PAYMENT OPTIONS (Please check your choice of payment options):

- ❑ When you make a payment in full and have no insurance for us to bill you will receive a 5% discount (Senior's get additional 5% if over 60 years of age) with check or cash.
- ❑ Payment by Visa or Mastercard (This option does not provide a cash or senior discount)
- ❑ Care Credit Payment Plan - If you need to finance the cost of your treatment, we offer different payment plans that can include interest free options for 3, 6 or 12 months or an extended plan at 12.96% interest for up to 48 months. These options are based on credit approval thru the credit bureaus.

Balances remaining after insurance benefits are received must be paid in full within 30 days. There will be a finance charge assessed equal to 1½ % (18% per annum on the unpaid balance) on any balances over 30 days past due.

Please let us know if you have any concerns or questions. We will review your payment options with you after we have a diagnosis and have determined the extent of treatment.

I have read, understand, and agree to the Payment Options. In the event my account is in default and must be turned over to collections, the undersigned agrees to pay all reasonable attorney fees and costs of collection.

We respectfully request a 24 hour notice for any appointments that need to be rescheduled, and ask that you call our office to make those changes. Please be advised there will be a $75.00 charge for any missed appointment.

Thank you.

Signed_____ Date _____

Print Name_____