Elegant Smile Dental

STATEMENT OF FINANCIAL POLICY:

Our office is committed to providing you with the best possible dental care. Your clear understanding of our financial policy is important to our professional relationship. Our office payment policy is that payment is due at time of professional services rendered. In order to assist you better, we provide you with the following payment options for your convenience:

1. Cash, Check, ATM card
2. Credit Cards (Master card, Visa, Discover) & *Care Credit (Dental Credit).
3. *Payment Plan (through Care Credit & other financing companies).

*Care credit will provide you with a dental line of credit similar to a credit card. Monthly payments as low as $20.00 may be made toward your initial balance with a minimum of 3 months to a maximum of 12 months interest free, based on your total charge.

INSURANCE: Due to the unpredictability of insurance reimbursement for dental care, we are not able to determine 100% guarantee of insurance benefits. Our office will retrieve dental benefits and bill your dental insurance company as a courtesy to you. We will collect a co-payment based on your dental treatment. All your benefits will be explained to you thoroughly by the front office. Should the insurance differ in payment that was originally expected, the patient will be held responsible for the difference in payment. If your insurance company has not paid the full balance within 30 days, you will have 7 days to pay the balance. If your insurance company pays more than the balance due, we will reimburse you.

Insurance is a contract between you and your insurance company. We are not a party to this contract. We cannot become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, “usual and customary” charges, effective and termination dates, etc. other than to supply factual information as necessary. You are responsible for the timely payment of your account. Our office will assist you in obtaining insurance reimbursement to the best of our abilities.

MISSED APPOINTMENTS: Unless cancelled at least 24 hours in advance, our policy is to charge $100/Hour for missed appointments.

I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 ½ % finance charge (18% APR) may be added to my account, in addition to any collection charges.

Patient’s or Guardian’s Signature:_____ Date:_____