

Office Guidelines

WELCOME! We at Advanced Dental believe in giving you the best possible dental care. We want you to feel welcome and as comfortable as possible throughout your treatment. This includes understanding your treatment plan as well as our financial policy. We realize that every person's financial situation is different. For this reason we have worked very hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile.

I would like to open an account: _____ **NO:** Payment is expected in full at time of visit. _____ **YES:** Personal credit may be checked.

Payment Options

Cash or check: We are able to offer a 5% pre-payment courtesy for treatment that exceeds \$300.00 and paid in full at time of treatment.

Credit Card: For your convenience, we have made arrangements to accept Visa, MasterCard, Discover and American Express.

CareCredit: Is a finance company we work with that offers interest free financing to patients who qualify. There are no monthly fees associated with this plan.

Optional Payment Plan: We will be happy to discuss financial options and arrangements with you to help you manage your treatment.

Consent

I authorize the doctor to obtain x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis. I will be giving the opportunity to discuss my treatment plan with the doctor and financial arrangements will be agreed upon before treatment is begun.

If care is being rendered on a minor child, I authorize the doctor to obtain x-rays and to treat my child as needed. I understand I will be given the opportunity to discuss the treatment with the doctor and that the parent or guardian who accompanies the child to the office is responsible for payment.

Missed Appointments

Your appointment is time reserved especially for you. If you need to cancel, please extend to us the courtesy of notifying us at least 48 hours before your appointment so that others may fill your spot. We reserve the right to charge \$50.00 for any missed appointment without a 2 business day notice and \$100.00 for appointments over 90 minutes in length. Please note we are closed on Fridays. Saturday appointments require a credit card on file and 1 week notice or there is a \$100.00 fee.

Financial Responsibility

Payment is expected at time of treatment unless prior arrangements are made.

1. Balances remaining beyond sixty (60) days from first billing will accrue interest at a rate of 1.5% per month of the unpaid balance (18% annual rate)
2. There is a \$30 charge for all returned checks.
3. Personal credit may be checked.
4. In the event of default, the responsible party promises to pay legal interest on the indebtedness, collection cost, and related attorneys' fees.

Dental Insurance

We are happy to file forms necessary to see that you receive the full benefits of your coverage; however, we cannot guarantee any estimated coverage. Unless prior arrangements are made, you will be expected to pay your portions services are provided.

Please keep in mind that we can only **estimate** your portion. If there is a difference after your insurance company has paid, it is your responsibility to pay the difference. Because the insurance policy is a contract between you and the insurance company, we will not enter into a dispute with your insurance company over you claim. We will provide information to support the necessity for treatment, which may assist you in recovering your benefits. Any balances not paid by the insurance company within sixty (60) days of submission become the patient's responsibility to pay at that time.

My signature will authorize assignment of insurance benefits to this office and release of information that the insurance company may request concerning treatment for myself and/or dependent(s).

Patient's Signature
(or Parent/Guardian/Responsible if Patient is a Minor)

Date