**PAYMENT IS DUE AT THE TIME SERVICES ARE PROVIDED,** i.e., your deductible and co-payments are due for examinations, dental cleanings and fillings at the time of your appointment. For extensive treatment(s) such as crowns, bridges, implants, dentures, partial dentures, and or root canal therapy our office requires one half of the total due at the start of treatment and payment in full when treatments(s) are completed; unless **prior** arrangements have been made.

**Payment Options**

A number of payment options are available to assist you in receiving the treatment you desire. We are happy to work with you to plan the most appropriate arrangements.

1. Cash, Checks or Money Orders
2. Visa, MasterCard and Discover
3. CareCredit and LendingClub – these are companies that offer a line of credit that can cover your entire family’s dental needs. Through them we can offer patients charging $500.00 and more 6 months interest free options.

**Insurance**

Your dental benefits are a contract between you and your insurance company. We are NOT a party to this contract. However, we will gladly bill your insurance as a courtesy to you. Your portion of the fee will be based upon available information, it is an **estimate only** and is due at the time of treatment. Although we may estimate what your benefits will be, it is the insurance company that makes the final determination of your eligibility and benefits. This may result in a balance after your insurance claim is processed. If you have a balance on your account, we will send you a statement with the remaining balance. Payment in full is expected unless prior arrangements have been made. The account is considered past due after 30 days. *It is your responsibility to monitor your benefits and annual maximum.*

**Other Charges**

* We reserve the right to ***charge a fee of $35.00*** for the time lost when a patient fails to provide at least 24 hours’ notice to reschedule an appointment.
* There is a ***$20.00 Charge*** for any check returned to our office unpaid.
* If your account becomes past due, there is a ***1.5% interest fee*** assessed to your account every month it remains outstanding.
* You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 25% of the debt, and all cost, and expenses, including reasonable attorneys’ fees we ***incur*** in such collection efforts and you will be dismissed from the practice.
* Should you need copies of your dental records or x-rays, we will be happy to provide you those copies for a processing ***fee of $25.00***.

One you have signed this agreement, you agree to all the terms and conditions contained herein.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_