FINANCIAL POLICY

Thank you for choosing us for your dental care needs. Our convenient financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees, and patients' financial capabilities.

PAYMENT POLICY:

Patient payment/co-payment is required in full at time of service.

This office does not extend personal lines of credit. A $35.00 service fee will be charged on all returned checks. Fees incurred to collect payment will be billed to and payable by the patient's responsible party.

We offer several convenient payment options:

- Cash, personal check, or money order (5% discount for services over $100)
- Visa / MasterCard / Discover / Debit Card
- Care Credit (no interest/short term and low interest/extended term plans available)

INSURANCE:

Our office is committed to helping patients maximize their benefits. As a courtesy to our patients, our office will file claims to the patient's insurance carrier when all current dental insurance information is provided. Our office recommends that each patient become familiar with their insurance coverage including deductibles, co-pays, and yearly maximums as each insurance company determines their own level of reimbursement. For major services, we can submit a pre-authorization, when requested.

Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. If you have any questions, our staff is always available to assist you.

MINORS:

Payment for services for the treatment of minors is the responsibility of the adult accompanying the minor and is due at time of service.

CANCELLED APPOINTMENTS:

Once an appointment has been made, that time has been reserved specifically for that patient. We understand that illness, emergencies, and bad weather occur. We ask our patients to give us 48 hours' notice, whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting to been seen.

As a courtesy, we provide our patients with a confirmation message (via email, text or voice) two weeks prior to their appointment, as well as a reminder 48 hours prior to their appointment to ensure they know the day and time and that they will indeed be present at their scheduled time. Patients who fail to give 24-hour notice of a cancelled appointment will be charged a cancellation fee of $25.00. Please note that we allow for two (2) broken appointments within a 12 month period and patients that exceed or abuse our policy will be terminated from our practice.

FINANCIAL CONSENT:

I authorize and hereby request my insurance company to pay directly to Summercrest Dental all insurance monies to which I am entitled for dental services. It is understood that any money received from my insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to pay all charges to Summercrest Dental not covered by this agreement.

X

Patient Signature (or guardian) *Date*