

FINANCIAL POLICY

Dear Patient:

We at GREAT SMILE are proud to be a part of a team whose primary mission is to deliver the finest and most comprehensive dental service available today. Thank you for choosing us as your health care provider. We are committed to providing you with a positive treatment experience.

Please understand payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you read and sign prior to any treatment. All patients must complete our information and our insurance agreement forms before seeing the doctor.

- FULL PAYMENT is due at the time of service.
- WE ACCEPT Cash, Checks or VISA/MasterCard.
- WE OFFER a financial service through Care Credit (Minimum financed - \$300.00).

Minor Patients

The adult accompanying a minor and the parent (or guardian of the minor) are responsible for full payment. For unaccompanied minors, treatment will be denied unless charges have been pre-arranged with a parent or guardian of the minor.

Regarding Insurance

Usual and customary rates

Since your insurance carrier must make a profit, you can only get back in benefits what you or your employer has put into the program, minus the profit. In other words, your particular insurance program may base its dollar allowance on a fee schedule, which does not realistically coincide with current, acceptable fees.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

We may accept assignment of insurance benefits on your second visit. However, we do require your percentage of the bill to be paid at the time of service. The balance is your responsibility whether or not your insurance company pays. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 90 days, the balance will automatically be the patients' responsibility. All account balances will be subject to a finance charge of 1.5% monthly (18% APR) after 120 days. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the insurance program and/or dental insurance.

If there is a balance after 90 days, the balance will automatically be the patient's responsibility. This balance will be charged to a credit card.

I, _____ authorize Great Smile to withdraw payments from the credit card listed below.
_____ VISA _____ MASTERCARD

Credit Card No. _____ Exp. Date _____

Signature _____ Date _____

Please circle the method of payment you are most likely to use:

CASH CHECK VISA MASTERCARD CARE CREDIT

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy:

Signature of Patient or Responsible Party

Date _____