PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT!

This form is our documented effort to inform you of our policy regarding processing dental claims to your insurance provider, including payment options for any out of pocket portions not covered. **WE** make every effort to inform you of your treatment needs, fees, estimated insurance coverages and financing options.

YOUR INSURANCE COMPANY does not participate with our dental practice. Insurance estimates are based on the information you provide and your dental insurance carrier. Any balances ***NOT COVERED*** by your dental reimbursement plan is due at time of your treatment, unless financing arrangements have been made. We offer 10% for our ***patients 65 and over*** with cash, check or debit card. Insurance estimates are based on the information provided by you and/or your dental plans. It is **your** responsibility to contact your insurance company to determine which services are covered under your plan.

We are required by law to inform you of the following:

- Any unpaid balances 90 days and over are subject to a $5.00 billing fee per monthly billing period. There is a $30.00 return check fee assessed to all accounts when a bank returns a check to us for insufficient funds.
- We reserve the right to charge $50.00-$100.00 for **TWO** consecutive broken appointments.
- An itemized statement listing your services will be mailed to you when the explanation of benefits is received from your insurance plan. Any outstanding balances are due within 15 days of the statement date.
- Not all services may be covered by your insurance plan. It is your responsibility to know what your insurance company plan provides.
- Delinquent balances left unpaid over 90 days without payment or communication from you may be sent to district court or a professional collection agency.
- **PLEASE INITIAL THE FOLLOWING METHODS OF PAYMENT WE OFFER :**

___ *I have dental insurance through _____.* Deductibles and out of pocket portions are due at the time of service. For treatment requiring lab services, all out of pocket balances must be paid prior to the insert date.

_____ Payment by cash or check at the time of service. (Ask about our Senior Citizen Discount of 10% for age 65 and over with check, cash or debit)

____ Payment by check at the time of service for any out of pocket amount not covered by your dental carrier.

_____ Payment by credit card at the time of treatment - (We accept MasterCard, Visa, Discover) for larger treatment cases over $500.00, we offer 5% for credit card payments, 10% for check/cash.

___ Automatic monthly billing to your MasterCard, Visa, Discover, or American Express. Any scheduled payments that are asked to be credited/ returned are subject to a $ 25.00 reprocessing fee. Any scheduled payments that are cancelled less than 72 hours prior to date approved to process, are charged an additional fee of $ 20.00.

(Additional *form to be filled out.)*

___ I wish to apply for outside financing through Care Credit for amounts $200.00 and over. Care Credit has their terms for financing that will be mailed to you directly. Promotional 0% interest rates for 6 months to a full year!

___ I wish to apply for Lending Club for amounts $ 500.00 and over. Promotional rates vary.

Please make your payment choice, sign and date below, and return to the receptionist before treatment.

I UNDERSTAND THE FINANCIAL POLICY TERMS FOR *SHREWSBURY FAMILY DENTISTRY*

Print: _____ **Sign and Date:** _____