PREMIERE DENTAL

# FINANCIAL POLICY

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand payment is due at the time of service. I understand any treatment fee will be honored up to 90 days from the date of examination. I understand, in order to collect any debt, my credit history may be checked through the use of my social security number and any other information given.

I agree that in the event my account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, costs, expenses, and court costs incurred in the collection.

Payment is due at the time services are rendered. For your convenience, we accept Visa, MasterCard, American Express, Discover, CareCredit, LendingPoint, Sunbit, among other credit providers. We apply a surcharge of 3.5% to payments made using a credit card, which is in line with our cost of acceptance. Any deductible or estimated co-payment amount will be due at the time of treatment.

I grant my permission to this office to phone or email me to discuss my account, appointments, or treatment.

As a courtesy to me, I understand this office will file any dental insurance for me. I hereby authorize release of any information needed and also authorize my insurance company to pay directly to this office benefits accruing under my policy. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

I understand this office will always do the best to help me maximize my dental benefits; however, ultimate responsibility for payment is mine and I am obligated and agree to pay this office in accordance with its credit terms and policy.

Patient/Legal Guardian Signature: _____ Date:_____