LIFETIME DENTAL EXCELLENCE
FINANCIAL INFORMATION

Your appointment, dental care and treatment are very important to us. The financial aspects of your dental care are a primary concern to all. To help clarify this, the financial policies of our office are outlined below.

You will be provided prior to your dental appointments with a written estimate. We ask that you pay at the time of each dental visit. Each patient is responsible for his or her deductible, co-pay and any procedures not covered by their dental insurance at the time of service. For your convenience, we accept cash, checks, debit cards, Visa, MasterCard, American Express and Discover card. We are happy to provide a 10% discount as a courtesy if treatment is paid in full on the appointment date. If insurance is paying a portion of your fees, then this does not apply.

For patients who wish to finance their dental fees, we offer 3 months same as cash for services over $200, as well as 6 or 12-month interest free financing through CareCredit© (www.carecredit.com) for services over $300. CareCredit also offers 24, 36, 48, or 60 month low interest payment plans for treatment fees of $1,000 or more. This will allow you to complete your dental work without delay and make smaller monthly payments. CareCredit applications are available at the reception desk.

We ask that you provide us with your dental health insurance information prior to your appointment. This is so we can provide you with a more accurate dental coverage estimate. We will file your insurance claims for you at no charge. Please be aware that we are only capable of approximating your portion, due to the large number of insurance companies and periodic changes with their contracts. We will try to give you the best estimate of what your dental insurance may cover.

A 1.5% per month service charge will be assessed on all accounts over 30 days unless prior financial arrangements have been made. The annual rate is 18%. Accounts that require further action will be turned over to a third party collector. The account holder of the outstanding balance will be held responsible for any costs associated with the process of collecting the debt. Any returned checks will be assessed with a $25 service charge.

We value and respect your busy schedule and we will make every effort to see you at your scheduled appointment time. We request that we are given 24 hours notice if you are unable to keep your scheduled appointment. There will be a charge for missed or cancelled appointments without sufficient notice.

I understand and agree, that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read and understand the above information.

Patient Name:____ Date:_______________
(Print)

Patient Signature:____