



Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. Please keep in mind that all fees will be collected at the time of your appointment. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care that you need and deserve. Dental treatment is an excellent investment in an individual's medical and psychological well being. Financial considerations should not be an obstacle to obtaining this important life enhancing care. We are always available to answer your questions or assist you in any way we can.

Payment Options:

For our Non-Insured Patients:

- We are happy to offer a 10% professional courtesy for all treatment paid in full cash, check, or Mac/Debit, at the time of treatment (Senior Citizens receive an additional 5%)
- We also offer Citi Health Card and Care Credit as alternate financial options.
- Payment may also be made using Visa, MasterCard, Discover, or American Express.

For our Insured Patients:

- We will be happy to submit dental claims to your insurance company; however, we can make no guarantee of coverage or payment. Since the policy is an agreement between you and your insurance company all patients are responsible for all charges, co-insurances, or non-covered services. Please know that we will do everything possible to see that you receive the full benefits of your policy.
- Estimated co-insurance amounts are due on the day of treatment and are not subject to the courtesy.
- For large treatment plans financing with Citi Health or Care Credit is also available.

Missed Appointments:

- Any patient that misses an appointment or does not give 48 hours notice will be subjected to a fee of \$40.00

Billing:

- If at time of service, any balance that is not paid in full, may be subjected to a billing and processing fee.

Additional Terms

- Please note that returned checks will be subjected to a processing charge of \$30.00.
- Any balance older than 60 days will become patient's responsibility to pay Dental Health Care Associates and to contact your insurance company for reimbursement.

I have read the above and understand the financial policy of Dental Health Care Associates.

(Signature of Patient or Guardian if under 18)

(Date)

(Printed Name of Patient or Guardian if under 18)