Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Late payment terms: A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. All returned checks will incur a $35.00 processing fee. If my account is placed in the hands of an attorney or collection agency for collection, I further agree to pay all costs and reasonable attorney fees, collection agency fees, court filing fees, and processing fees.

Refund Policy: Once services are performed, there are no refunds.

Broken Appointments: We reserve appointment times especially for you. We ask that you give us at least 24 hours notice of a cancelled appointment. Accordingly, if 24 hours notice is not given, we have the right to charge you $50.00 as a broken appointment fee.

Insurance Consent and Financial Terms

In order for us to help prepare your insurance forms and assist in making collections from insurance companies to credit to your account, we will need the following authorizations: I have been informed of the treatment plan and associated fees. We accept assignment of estimated insurance benefits as a courtesy to our patients. Please note that your dental insurance is a contract between you and the insurance company. If insurance does not cover your treatment, in whole or part, or is cancelled or terminated for any reason, or cannot be verified, you will be responsible for the entire fee. As a courtesy to you, we use available information to estimate for you how much your insurance will pay and how much you will need to pay. We are not responsible if our estimate is incorrect. You are solely responsible for understanding your insurance benefits. It is important that you understand that in most cases your insurance is designed to reduce your cost, not eliminate it completely.

I agree to be responsible for all charges for dental services and materials not paid for by my dental benefit plan, unless prohibited by law, or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Smiles By Design, PLLC.

I HAVE READ THIS POLICY CAREFULLY AND FULLY UNDERSTAND AND AGREE TO ALL ITS TERMS.

_____ Date: _____

Name of patient, parent or guardian

_____ Date: _____

Signature of patient, parent or guardian