**The Smile Center**

**Financial Policy**

Payment in full is expected when services are rendered. All other arrangements must be made prior to your appointment.

**Patients with Dental Benefits**

* Although your benefits may assist you with partial payment of your treatment, the estimated portion that is not covered is due when services are rendered.
* As a courtesy to our patients, we will file your primary dental benefits for you. If your dental benefits have not paid within 60 days, you will be responsible for the entire unpaid balance and payment in full will be expected at this time. We will however, continue to work with you and your dental benefits plan to expedite your reimbursement.

We do not accept assignment of benefits for secondary dental benefit plans, however, we will provide a claim form for you so that you may file and be reimbursed by your plan.

Payment may be made by any of the following methods. Please indicate your method of payment below.

**CASH \_\_\_\_\_ CHECK\_\_\_\_\_\_ CREDIT CARD\_\_\_\_\_\_**

Information is available upon request for third party financing through the following:

**CARE CREDIT LENDING CLUB ICARE**

* I understand and agree that I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my dental claim(s) by my benefit plan.
* I agree to pay and all unpaid balances on my account.
* I authorize all my dental plan benefits paid directly to THE Smile Center.
* If payment by the dental benefit plan is made to the policy holder, I agree to endorse or have the policy holder endorse the benefits check to The Smile Center, or make payment directly to The Smile Center.
* I authorize the release of information to my dental benefits plan, attorney, or legal representative to obtain reimbursement of any claim(s) or for the other reason.
* A finance charge of 1.5% will begin to accrue after 60 days from the date of service on the unpaid balance of my account even though my dental benefits plan may pay.
* A fee of $29.00 will be incurred for each returned check.
* I agree to pay collection cost, attorney’s fees, court costs, and interest from the date of treatment if this account is assigned to collection status.
* I have read, understand, and agree to the above terms.
* I authorize this office to discuss my account with a spouse or parent/step parent (if patient is a minor but using parent/step parent benefits).

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Signature of responsible party Date

**Acknowledgement of receipt of Notice of Privacy Practices**

I have been given the opportunity to receive a copy of the Privacy Practices and understand I can decline signing this acknowledgement.

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Signature of responsible party Date