PAYMENT OPTION AGREEMENT
Financial Policies of Wendell Family Dentistry

Patient Name: _____ **Date:** _____

If patient is a minor:
Designated Family Member / Caregiver / Guardian: _____
Attached: Legal Guardianship Documents and/or Healthcare Power of Attorney

We appreciate your trust and choosing us to help you achieve your oral health goals. Our goal is to provide the highest quality dental care for you and your family. At the same time, we would like to establish a healthy relationship with our patients, by explaining the necessary treatment and associated fees in advance of treatment. Please check the desired option for payment, placing a check mark in the box below.

OPTION ONE – Pre-pay: *Total Fee*

☐ I would like to take advantage of the prepayment option and receive a **5% courtesy** by paying the planned treatment in full, **one week prior** to the appointment by check, cash, or credit card. *This option applies to prepaying for all phases of treatment prior to initiating treatment. Generally, these treatment plans require multiple appointments and are greater than $3000 in total services.

OPTION TWO – Pay per visit: *Estimated Co-Payment*

☐ I would like to pay the copayment or estimated portion not covered by insurance at each visit by cash, check, or credit card. I understand that my copay is due at the time of service. The insurance benefits will be assigned to the dental practice directly. Any remaining balance not covered by insurance will be paid by the responsible party in full, **within 30 days** of the statement.

OPTION THREE – Monthly Payments: *Care Credit Financing*

☐ I would like to take advantage of the recommended healthcare finance company, Care Credit, making monthly payments to them directly for services rendered in this dental practice. I understand that financial arrangements are with the third party lender and requires me to fill out credit application to be approved. This process be completed in 1-2 minutes online or by phone.

Accounts regarding minors (<18 in NC): the parent or legal guardian bringing the child for treatment will be held responsible for payment at the time of service unless other prior arrangements have been made. We ask that you remain in the office during treatment for emergency reasons and due to possible changes in treatment that require your consent. Consent to treat the minor is required by at least one parent or legal guardian or in accordance to any divorce decree. We will not agree to 3rd party participation in parental disagreements. However, we are happy to provide you with any appropriate treatment information requested.

Past Due Accounts: For all accounts that are 60 days past due, there will be a 1.5% interest accrued on monthly basis until the balance is paid in full. All accounts that are 90 days past due are subject to a $18.00 finance charge.

Returned Checks: a $25.00 charge will be added to your account for all returned checks. Your bank, by law, must inform you of a non-sufficient funds check. We expect you to contact us to make arrangement for settling the full amount of the check plus $25.00, within five (5) days.

Insurance Policy: As a courtesy, we will assist you in filing your insurance, however we would like to emphasize that, insurance is an agreement between you, your employer, and your insurance carrier. We are not a party to that agreement and believe that your insurance should not dictate your treatment plan by the dentist. However, we will be happy to assist you in maximizing your dental benefits. **Your insurance coverage and estimated patient portion is based on verbal information provided by your insurance company. Any balance, for any reason, not covered by insurance is yours.** As an added precaution, we encourage you to verify your benefits by calling your insurance company prior to beginning treatment. Unlike medical insurance, dental insurance is a form of financial assistance similar to a rebate and not intended to pay for care in full.

Insurance Checks: Occasionally your insurance carrier will send payment for services rendered directly to you rather than our office. It is your responsibility to bring those payments along with the Explanation of Benefits (EOBs) to our office (or mail it to us) so that we can credit your account.

Missed Appointments: Appointments reserve a specific time with the dentist or hygienist to perform and provide the care you need. These scheduled times are planned for your convenience and hold great value. We typically schedule and staff our office so that you receive individual one on one attention and thus each appointment is important. We do not double book unless emergency walk-ins occur. Any appointment that is not kept or rescheduled within one business day (24 hours) will be charged up to **$50, after the first failed appointment.** If you are more than **15 minutes late**, we may need to reschedule the appointment which will result in a cancelled appointment fee. We do this as to not inconvenience patients that have scheduled appointments after your appointment. We ask that all of our patients be on time and trust that you will keep your scheduled appointment(s).

By signing below, I (we) agree to the financial option I (we) have chosen and further acknowledge the receipt of the policies set in place. It is has been explained that any delay in treatment may result in health risks, the need for additional dental or medical procedures and associated fees that may not be covered by insurance, or any third party.

Signature of Patient/Legal Guardian:

_____ Date_____

Witness:

_____ Date_____