Caring Smiles

You'll love our care and your smile will show it!

Welcome to our practice! Please take a few moments to review the following information regarding our financial policies. These policies have been established to assure the financial resources needed to provide high-quality patient care.

Charges for dental services are due and payable at the time of service. We accept cash, check, debit card, Visa, Mastercard, American Express, Discover, and Care Credit.

For patients with dental insurance:
If you have dental insurance benefits, please bring a copy of your current insurance card with you to your first appointment. If we participate with your dental insurance plan, we will submit your dental insurance claim for you as a courtesy and accept assignment of benefits to receive payment directly from your insurance company. We expect payment of your estimated patient portion at the time of the service. If a payment from your insurance company results in a credit balance or an unpaid balance, a refund or invoice will be sent to you promptly.

- The amount of insurance coverage is an estimate only and may not reflect what your insurance carrier will actually pay. The insurance company will make final determination once the claim has been processed.
- Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
- Not every service is a covered benefit with all insurance contracts. Some insurance companies are selective in what services they cover.
- Waiting periods, copayments, deductibles, exclusions, and contract limitations may be present in your dental insurance plan. You, as the insurance subscriber, are responsible to know of any such exclusion. We encourage you to contact your insurance company directly to understand your dental insurance benefits.
- Services cannot be provided on the assumption that the charges will be paid by the insurance company. **You, as the patient, are ultimately responsible for the complete cost of your dental treatment, regardless of insurance coverage**.

Senior Courtesy: For uninsured patients over age 65, we offer a 5% courtesy for payment in full by cash or check at the time of service. This cannot be combined with the prepayment courtesy or utilized with insurance benefits.

Prepayment Courtesy: For patients who are uninsured and not utilizing the senior courtesy policy, we offer a 5% prepayment courtesy for prepayment of qualified treatment plans **in full** by cash or check **before** the services are rendered. This only applies for treatment plans over $1,200.

Cancellation/Failure Policy: Any changes to appointments must occur at least 2 business days prior to the scheduled appointment. A cancellation fee of $75 may be charged if an appointment is cancelled or missed with less than 2 business days notice.

Additional Charges: Any check returned from the bank for "insufficient funds" will result in a $20.00 charge on your account. If a check is returned for insufficient funds, it may be re-presented electronically to your bank, and you will be assessed an additional processing fee of $20-$30 or the maximum amount allowed by law. The check writer is also responsible for other check recovery costs including all attorney fees, court costs, and taxes. If your account is turned over to a collection agency for failure to abide by the terms listed above, you will be responsible for all collection fees, attorney fees, and court costs. A billing charge of 1.5% per month will be assessed on accounts that are not paid in full within 30 days of billing.

I understand that I am financially responsible for the entire amount of my dental services. Payment is due at the time of service unless other financial arrangements have been documented in my chart. When applicable, a claim will be filed with my insurance company. I hereby assign my payable insurance benefits to Caring Smiles for application to my bill. I am responsible to pay any amount that the insurance does not pay. I authorize the release of any information necessary to process my insurance claim.

Signature: _____ Date: _____

Printed Name: _____ Witness: _____