



Financial Policy

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care. The following is a statement of our financial policy.

Regarding Payment

Please understand that payment of your **estimated** patient portion is considered part of your treatment. We ask that all patients please come prepared with any copays, deductibles, etc. as we will need to attain those before treatment is rendered.

We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options:

1. We accept the following forms of payment: cash, AmEx, Discover, Visa, and MasterCard.
2. Flexible payment plans of 6-12 months no interest (based on cost of treatment) upon approval with CareCredit®. Approval must be received prior to treatment date.

Checks are only accepted should payment be mailed in from a statement received and not at the time of service. Checks that are returned to our office from your financial institution are subject to a \$30 return check fee.

If dentures, crowns, and/or bridges, retainers, mouth guards, or bleach trays are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.

The adult that accompanies any minor to their appointment is responsible for any payment due. For unaccompanied minors, treatment will need to be pre-paid or payment sent with the minor in order for treatment to be rendered. In a divorce situation, the parent or guardian who fills out the minor's paperwork will be considered financially responsible. We are unable to legally send a bill to the other party.

Regarding Insurance

As a courtesy to you, we will gladly submit your insurance claims. Our responsibility is to provide you with treatment that best meets your needs. Dental insurance plans do not correspond to individual patient needs, and as such, some routine and necessary dental services are not covered even though you may need those services. Your insurance company makes final determination once treatment is completed. Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility.

Your complete insurance information along with a valid ID must be presented at the time services are provided. Insurance claims cannot be backdated. If we are unable to verify active dental coverage and/or insurance information is not presented at the time of your appointment, you will be required to pay our office fees at the time of service.

Regarding Appointments

Your reserved time in our office is important. We understand that sometimes it is necessary to change your appointment so we ask you kindly give us a minimum of two business days' notice. Without this notice, we are unable to offer treatment to other patients. If two or more appointments are broken, cancelled, or rescheduled without proper notice, a cancellation fee of \$50 per hour will be applied to your account and if necessary, all future appointments will require a "good faith" deposit.

Regarding Nonpayment and Past Due Accounts

I agree that I am responsible for any debt regardless of my insurance and I agree to pay my unpaid balance within 60 days of the date of service. I understand there will be an 18.5% interest charge per annum on the unpaid balance. In the event that my account is not paid as agreed, I understand that I will have to pay a collection agency fee up to 50% of my unpaid balance including interest charges of 18.5% to the collection agency in addition to my balance. The collection agency may use any information given including cell phone numbers to collect. In the event that it is necessary to commence legal action to collect this bill, I agree to pay all attorney fees and court costs.

Thank you for taking your time to read, understand, and agreeing to Masterpiece Dental's financial agreement.

Signature of patient or responsible party: _____ Date: _____