

## Financial Policy for Our Patients

Our office wants all our patients to be able to comfortably afford dental care. We proudly offer the following financial policy so that our patients can have the opportunity to decide which payment option best suits your needs:

**INSURANCE:** Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Because of this, you will be asked to pay your deductible and your co-payment for the charges on the day the service is rendered. **Also for all treatment under \$100, excluding preventive treatment, you will be asked to pay in full.** We will estimate as closely as possible your coverage, but we can make no guarantee of any estimated coverage.

Because the insurance policy is an agreement between you and your insurance company, the ultimate responsibility for all charges lies with you. ***If after 60 days the insurance company has not paid on a claim, you will be responsible for the total balance.***

### **PAYMENT OPTIONS:**

1. **Cash, Check or Debit.** We are happy to offer a 5% courtesy discount for anyone without insurance. We also offer a **5% pre-payment courtesy for all treatment paid in full in advance prior to the date of treatment.**
2. **Credit Card.** Our office accepts VISA, MasterCard and Discover.
3. **Outside Financing.** Option 1- **Care Credit-** A dental credit card that can be applied for through our office with an outside company. The application is done in our office, and we know immediately if the applicant is approved.
4. Option 2- **Springstone-** A dental credit card that can be applied for through our office with an outside company. The application is done in our office, and we know immediately if the applicant is approved.
5. **Sr. Citizen Discount.** As a courtesy to anyone 60 years or older, we will gladly discount your fee by **5% if services are paid at the time of treatment.** However, this excludes any treatment for Implants, Dentures and Partial Dentures.

I hereby assign to Dr. Lucio the insurance benefits which are otherwise payable to me for his charges and direct that insurance payments be made directly to him. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I agree that I am fully responsible for the total of all procedures performed in this office. I understand that there is a one and one-half percent (1.5%) per month interest (18% annually) will be charged to my account for outstanding balances over 60 days. I understand that I will be charged \$25.00 for any returned checks. I hereby authorize assignee to release all information necessary to secure the payment.

*By signing below, I understand and agree that a broken appointment fee will be assessed at the rate of \$25.00 per 30 minutes of scheduled time for cancelations of appointments with less than 24 hours notice. I understand that if I miss 3 appointments I may be dismissed from the practice.*

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Signature of responsible party

Date