All Smiles Dental

Financial Policy

Thank you for choosing All Smiles Dental as your dental health provider. We are dedicated to providing the highest quality dental care in a cheerful, caring environment. We believe that each patient deserves professional and personal treatment.

We offer several payment options and are happy to provide you with treatment estimates ***before*** treatment is started.

Payment Options:

- Payment in full on day of each visit. We accept :
  - Cash
  - Check
  - Debit Cards
  - Master Card, Visa
  - Health Savings/Flex Spending Accounts
- No Interest Payment Plans from CareCredit
  - Allow you to pay over time with no interest *(if paid within promotional period)*
  - Convenient, low monthly payment plans also available
  - No annual fees or pre-payment penalties

Our goal is to help you maximize your dental benefits. As a courtesy, we are happy to bill your insurance. Please remember that we can provide clarification with regard to what should be covered, however, you are ultimately responsible to understand your policy. If your dental plan does not pay within **60 days** of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. If your dental plan pays more than expected, you will receive a refund check within 1 month.

There is a $25 fee charges for all returned checks.

Accounts left unpaid for more than 90 days will be sent to a collections attorney.

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*I have read the information above and accept full financial responsibility for this account and for all dentistry performed on my dependents in this dental office. I understand that it is my responsibility to confirm insurance eligibility, waiting periods and benefits. I also understand that this office cannot guarantee my insurance status in any of these areas. Any insurance estimate or information given to me by this office is not a guarantee of actual insurance payment. I also understand that if the insurance claim not paid in full after **60 days** it will become my responsibility to pay. I further agree to pay all collection costs including reasonable attorney's fees and court costs in the event I fail to pay as agreed. As a patient of All Smiles Dental, I consented to treatment, financial responsibility and release of medical information, at the time services were completed.*

Patient or Parent/Guardian Signature: _____

Date: _____

Patient Name (please print): _____