

PREMIER DENTISTRY

COSMETIC, RESTORATIVE, AND SEDATION DENTISTRY

PAYMENT POLICY

In an effort to keep dental costs down while maintaining a high level of professional care, we have established the following payment policy:

1. **PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT.** We offer the following payment options: Personal check, Credit card (Visa, MasterCard, American Express, Discover), CareCredit, and iCare. There is a **\$35.00 charge** for all returned checks.
2. New patients being seen on an emergency basis are required to pay for services at the time of visit.
3. Patients with PPO dental are required to pay their deductible and an estimated percentage of the fees not paid by the insurance company. To help in estimating your costs, a copy of the policy benefits should be brought into our office.
4. As a service to our patients, we will submit claims to your insurance company (provided that it is a PPO).
5. Patients without dental insurance are required to make payment when services are rendered.
6. Any fees not paid by the insurance company within 60 days from the date of service become the responsibility of the patient. All payments are due within 60 days of the billing date.
7. The portion paid at the time services are rendered is only an **ESTIMATE** of what your insurance may not pay. If an overpayment should occur, a check will be issued to the patient.
8. Appointments canceled with less than 24 hours' notice **WILL BE BILLED** accordingly.
9. If it is necessary, individual payment plans may be arranged with the business office **PRIOR** to scheduling appointments.

I HAVE READ AND I UNDERSTAND THE ABOVE POLICY. I AGREE TO COMPLY WITH THE TERMS.

SIGNATURE: _____ **DATE:** _____

FULL NAME (PLEASE PRINT): _____