THE STUDIO
· FOR EXCEPTIONAL DENTISTRY ·

FINANCIAL POLICY

Thank you for choosing The Studio For Exceptional Dentistry as your dental care provider. Our primary mission is to provide you with the best and most comprehensive dental care available in a comfortable and relaxing atmosphere. Please understand that payment of your bill is considered as part of your treatment. An important part of our commitment is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

The following is a statement of our Financial Policy which we require you to read and sign as a patient of our practice in order to minimize any misunderstandings of payments for treatment and your insurance policy.

PAYMENT OPTIONS:

You may choose from:

~Visa, MasterCard, American Express, Discover, Cash, or Check payments

~No Interest Financing/Long Term Payment Plans
-Allow you to pay overtime with no interest or make convenient low monthly payments with no annual fees or prepayment penalties
*Care Credit
*Lending Club Patient Solutions

~In office payment option with an automatic monthly credit card agreement

DENTAL INSURANCE:

As a courtesy to you, we will file insurance claims for all services rendered; however, please be aware that deductibles and co-pays are due at time of service. We do our best to gather all of the information possible from the insurance company about your specific plan in order to give patients the best **estimate** possible for treatment. A treatment plan with estimated insurance coverage is just that, an **estimate**. There is never a guarantee on what insurance will cover, so please keep in mind that your insurance policy is a contract between you and your insurance company. We are not a party to that contract and ultimately, the patient/guarantor is responsible for knowing and understanding their own plan. Important points to know about your policy: DEDUCTIBLES, CO-PAYS, MAXIMUMS, FREQUENCIES, COVERED AND NON-COVERED SERVICES, AND MISSING TOOTH CLAUSES. In the event we do accept assignment of benefits and your insurance company has not paid their expected portion in full within 90 days, the balance may be transferred to your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients, we charge what is the usual and customary for our area, and we do not allow insurance to dictate treatment recommended by the Doctor. You are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates or any other restrictions they may impose.

THE STUDIO FOR EXCEPTIONAL DENTISTRY RESERVES THE RIGHT TO THE FOLLOWING:

~Returned Check Fee
*Checks that are returned to our office from your financial institution are subject to a $35.00 returned check fee. This fee covers the processing fees that are charged to our office.

~Collections and Fees
*Unpaid balances may be sent to collections and you will be subject to a 30% interest charge.
*Attorney's fees may apply if collection must be pursued through the civil court system. You will be responsible for costs associated with collection , including attorney's fees and court costs.

~Interest
*Balances over 60 days past due are subject to an 18% APR monthly compounded interest charge.

~Cancellation/No Show Fee
*A $25-$50 cancellation/no show fee may be charged to your account if multiple delinquencies occur.

We are happy to discuss any charges on your account and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

Signature of Patient or Responsible Party:_____ Date:_____