Financial Policy

We at Dr. Gardner's office are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive dental care available today. In addition, we are also dedicated to making top-quality care as cost effective as possible. To assist you with your healthcare investment, we provide the following payment options:

Payment Options

1. **Cash**: includes money orders and personal checks.
2. **Visa/MC/Discover/AMEX**: we accept credit cards as payment for treatment.
3. **CareCredit**: the financing plan we offer as a separate line of credit to cover you and your family members' dental care needs. With CareCredit* you enjoy these benefits:
    - Flexible financing options with NO money down (Including 12 months Interest fee**)
    - Credit decision usually only takes a few minutes
    - No annual fees or prepayment penalties

We are happy to provide you the above options to allow you to make convenient, low monthly payments. If CareCredit is your preferred option, you can begin any necessary treatment immediately and spread the payments out over time*. For more information, ask for a CareCredit brochure or call our office and we would be happy to answer any questions you have.

We look forward to seeing you at your next scheduled appointment. We are pleased you have chosen to become a member of our patient family.

Sincerely,
Smile Docs

_____ _____

Patient/Guardian Signature Date

*Subject to credit approval
**Any treatment over $1000 qualifies

FINANCIAL POLICY

We are committed to providing you with the best possible care. In order to achieve this goal we need your assistance and your understanding of our payment policy. Payment for services is due at the time services are rendered unless other arrangements have been approved in advance by our staff. We accept cash, check, credit card, or care credit.

We will gladly discuss your proposed treatment and answer any questions you may have. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Not all services are a covered benefit in all contracts. Some plans arbitrarily select certain services they will not cover. We encourage you to talk with your insurance company and familiarize yourself with your plan.

In most cases we can file your insurance for you. We will do our best to estimate for you what insurance will pay and what the patient portion will be for your treatment. **The estimated patient portion will be due at the time of treatment. Any amount not paid by your insurance, regardless of the reason, is your responsibility.** We therefore **require** a credit card to be on file for any balance not paid by your insurance company.

Financial Information

PREFFERRED METHOD OF PAYMENT:

☐ Cash / Check on **Day of Treatment** ☐ Care Credit

☐ Visa / Master Card / American Express / Discover / Debit Card

Credit Card # _____ Exp date _____

Cardholder Signature _____ Security Code _____

Person responsible for this account: Relationship: Phone #

_____ _____ _____

Address: _____

Terms & Conditions

As a Condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends on reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of 1 ½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of 90 days from the date of the patients examination.

In consideration of the professional services rendered to me by the Doctor and/or his staff, I agree to pay for all treatment performed to said Doctor, or his assignee, at the time said services are rendered, or within (5) days of billing if credit shall be extended. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that this office shall institute any legal proceedings against me with respect to amounts owed by me for services rendered I will be responsible to pay all costs incurred including all attorney's and/or collection fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

Signed _____ **Date** _____