First Name:	Last Name:	Birth Date:

FINANCIAL POLICY / PAYMENT OPTIONS

Our mission is to deliver the best and most comprehensive dental care, and financial considerations should not be an obstacle in fulfilling your needs. Therefore we provide a range of payment options for our patients.

CHECK, DEBIT CARD, VISA, MASTERCARD, DISCOVER CARD, OR AMERICAN EXPRESS

For all appointments, one-half of the treatment fee is due at the time of scheduling, or at a minimum of two weeks prior to your scheduled appointment and the balance is payable at time of service.

COMPREHENSIVE CARE DISCOUNT

A 5% courtesy discount may be extended to patients who pay the full treatment fee by cash, check or charge at the time of scheduling. This discount applies to treatment in excess of $2500 and must include treatment for multiple services. This discount cannot be extended when used in conjunction with third-party financing.

THIRD-PARTY FINANCING (Monthly payment plans including no-interest and extended period plans)

Flexible monthly payment plans are available from third party companies such as Care Credit, Springstone and others (the "Financing Companies"), subject to credit approval. We are able, in many instances, to obtain credit approval even if you have a limited or negative credit history.

INSURANCE PLANS

We accept most dental plans and we will work to maximize your dental benefits and submit your insurance claims at no charge. For your convenience, we accept the insurance benefit directly from your insurance company, and only the estimated portion not covered by your insurance is due at the time treatment is performed or at the time of scheduling. However, we make no guarantees of your insurance reimbursement, and if we do not receive payment in full from your insurance company within 60 days, you will be responsible for the unpaid insurance portion. Services not covered by insurance will not be submitted to your insurance company.

Assignment and Release: You, the undersigned, assign directly to City Smiles, all benefits, if any, otherwise payable to you for services rendered. You hereby authorize the doctor to release all information necessary to secure the payment of benefits. You authorize the use of your signature on all your insurance submissions whether manual or electronic. In order for City Smiles to accept assignment of benefits, we require a credit card on file with our office to cover any unpaid balance not covered by your insurance company. If you choose not to have a credit card on file, we expect full payment, by the patient, at time of service, unless other financial arrangements have been made. Your insurance company will reimburse you directly.

FLEXIBLE SPENDING ACCOUNTS AND HEALTH SAVINGS ACCOUNTS

If you work for a company that provides a flexible spending account, or a "flex-plan," or a health savings account, we will accept payment from these sources directly or provide you with statements so you can receive reimbursement under these plans. We cannot guarantee reimbursement or what services will be covered under the terms of your specific plan.

PLEASE NOTE

We require payment or a financial arrangement before the start of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

Your appointments have been reserved exclusively for you. If you are unable to come for your appointment, *please notify our staff at least 24 hours in advance* so that we may offer that availability to another patient in need of treatment. If you cancel your appointment with less than 24 hours notice or are late for your appointment such that your scheduled treatment cannot be completed, your account will be charged a $50.00 cancellation fee.

When scheduling appointments to receive services in excess of $500 or that are expected to last 1 hour or longer, City Smiles requires one-half of the patient portion (this excludes any estimated insurance payment) to be payable at the time of scheduling or at least two weeks prior to the scheduled appointment.

For your protection, and to constantly improve the quality of care we deliver, phone calls to our office may be recorded. A late charge of $5.00 or 1.5% per month will be applied to unpaid balances. There will be a $25 charge for all returned checks.

I have read the Financial Policy in its entirety and I understand and agree to all its terms.

Patient, Parent or Guardian Signature _____ **Date:** _____
(Must be 18 years or older to sign)