PREMIER DENTISTRY

COSMETIC and RESTORATIVE DENTISTRY

PAYMENT POLICY

____ ________/________/__________

Patient's Name (Printed) Date

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, iCare, Lending USA, Lending Club and Sunshine State Credit. There is a **$35.00 charge** for all returned checks. **ALL SALES ARE FINAL.**
2. New patients being seen on an emergency basis are required to pay for services at the time of visit.
3. As a service to our patients, we will submit claims to your insurance company, provided that it is a PPO.
4. Patients with PPO dental insurance are required to pay their deductible and an estimated percentage of the fees not paid by the insurance company. All dental insurance fees are **ESTIMATES** and should be treated as such.
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.
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.

____ ______/______/______

Patient or Responsible Party's Signature Date