Bellefonte
FAMILY DENTISTRY

Financial Options and Arrangement

Patient Name: _____ Date: _____

Parent/Guardian: _____ Date: _____

Taking care of you and your family is our top priority. That's why, when it comes to talking about finances, it's very important for us to avoid misunderstandings by being clear with all fees and financial options. The result of this form is a *Financial Agreement* that we ask you to sign and an office representative to sign so that we can both count on clarity in this important matter.

A Returned check fee of $35 will be charged for any check returned for insufficient funds.

At the onset of your treatment, we will provide you with an estimate of the total fees expected. Please understand that it will be an estimate *only.* Treatment sometimes changes for a variety of unforeseen reasons. When it comes to estimating insurance payments or coverage, we must also stress the word estimate, as insurance companies continue to surprise us at times. If the insurance company pays more than expected, you will receive a refund. If they pay less than expected, a balance due will be reflected on your monthly statement. If they deny your eligibility after the fact, the balance becomes your responsibility.

Thank you for reviewing our financial options and indicating your choice of payment. We appreciate the confidence you have placed in us caring for you and your family and remain available to you at any time to assist you with your account. Again, please feel free to contact us with any questions regarding the payment option plans listed on the next page.

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Plan A: Payment in full

A 5% Courtesy for payment in full at the start of treatment for procedures over $500. For senior patients, those 65 or older and with no dental insurance, we offer a 10% courtesy fee reduction for payment at the time of service.

Plan B: Monthly Payment Plan

For our patients who want to make monthly payments, we offer short and long-term financing through Care Credit. A member of our office staff will gladly assist you with the application process.

Plan C: Insurance Coverage

Our goal is to do whatever it takes to help you maximize your insurance benefits, and as a courtesy, we are happy to bill your dental insurance for services. If your insurance does not pay within 90 days, Bellefonte Family Dentistry reserves the right to request payment in full for services from you and let you collect the insurance funds that are due. This is rare, but it is important for you to recognize that the insurance that you have is a legal contract between *YOU* and your insurance company. Our office is not, and cannot be a part of this contract. Ultimately, you are responsible for all your charges incurred in our office. Please remember that your estimated portion is due in full the day of treatment. You may use one of the other payments plans to pay your portion.

I, _____, have chosen option _____ above, and accept full financial responsibility for this account. I understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment or coverage. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon my dependents in this dental office. Any insurance claim not paid in full after 90 days will become my responsibility to pay at that time.

Also, by signing this form, you give consent to complete any treatment as discussed between you and your dental provider. A treatment plan will be given to you to review prior to starting your dental treatment.

Name (Please Print): _____ Date: _____

Signature Patient/Guardian: _____ Date: _____

Witness Signature: _____ Date: _____