LE CENTER
Dental Clinic

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FINANCIAL POLICY/ACCOUNT INFORMATION

PATIENT (or) SUBSCRIBER OF INSURANCE

NAME _____ MIDDLE _____ LAST _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE # _____ CELL # _____ WORK # _____

DATE OF BIRTH _____ MARITAL STATUS _____

EMPLOYER _____

PATIENTS: SPOUSE _____ DOB _____ PHONE # _____

DEPENDENT CHILDREN: _____

DEPENDENT CHILDREN: _____

DEPENDENT CHILDREN: _____

DEPENDENT CHILDREN: _____

Welcome to our practice! Our primary concern is to provide high-quality care to all our patients. So that there are no misunderstandings, we are providing you this Financial Policy and Account Information to read and sign prior to treatment. In order to keep down the cost of care, we have the following financial guidelines:

IF YOU DO NOT HAVE INSURANCE: (_____) initial

1. We require payment of our fee on the day of services, unless prior arrangements have been made.
2. You may make this payment by one of the following methods: CASH – CHECK ($30.00 charge on returned checks) MONEY ORDERS – VISA/MASTERCARD/DISCOVER – CARE CREDIT
3. When fees are paid in full on the day of services, you will receive a 5% discount if you pay with cash or a check.
4. For approved patients who are unable to pay on the day of services we offer an Extended-Payment Plan through Care Credit that offers monthly payments with no or reduced interest. You can apply by calling (800-365-8295) or online at www.carecredit.com

IF YOU HAVE DENTAL INSURANCE: (_____) initial

1. We are happy to file your insurance claims and assist you in maximizing your dental benefits.
2. You must provide your complete insurance information at the time services are provided.
3. Insurance claims cannot be backdated.
4. Pre-authorizations for services will be sent to your insurance company before the services are provided, for crowns, bridges, dentures, partials, root canals, or any large treatment plans.
5. The patient or guarantor is responsible to pay any difference in our fees and what is reimbursed by the insurance company. The amount that the insurance company pays varies greatly depending on the contract negotiated by either you or the employer.

Outstanding balances are discouraged. We reserve the right to assess a finance charge of 1.5% per month (18% annually) allowed by law to any balances over 30 days old.
Late cancellations and failed appointments are discouraged. There is no charge to change an appointment provided we receive at least one business days notification.
Thank you for understanding our financial policy. If you have any questions or concerns, please direct them to our staff and they will be happy to answer them for you.

I certify that I have read and understand this financial policy, and I agree to its terms. This signature on file is my authorization to release information necessary to process my and/or my dependents claims and to release information to other health care providers about my and/or dependents history, examinations, and treatment course. I hereby authorize payment to this office and I agree to endorse all insurance company checks and forward them immediately to this office.

_____ _____

Signature of patient and/or guarantor Date