SMALL HANDS, BIG HEART

WILLDEN
FAMILY DENTAL

PAYMENT OPTIONS

At the onset of your treatment, we will provide you with an estimate of your treatment costs. Our goal is to help you plan for dental care. Please understand that this is only an *estimate*. Should the need for additional treatment arise during the course of the original treatment plan, the fees could change. Be assured that we will notify you of fee changes and obtain your approval prior to proceeding with treatment.

If you have dental insurance, we recommend a pre-determination/insurance authorization for treatment over $500.

Outstanding balances must be paid before additional treatment can be scheduled.

Please take a moment to review the financial options offered and indicate your choice of payment:

☐ **Plan A**: Payment in full on the day of each visit. You may use your check, cash, and/or credit or debit card. We accept Visa, MasterCard and Discover.

☐ **Plan B**: We offer an extended monthly payment plan option through a dental financing company, **Care Credit**. Please see our receptionist prior to treatment for more details.

☐ **Plan C**: Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental carrier for services. Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance carrier. Regardless of coverage, your estimated co-payment is due in full the day of treatment. The amount your dental plan contributes towards your dental care is based on the plan selected and purchased by your employer. **Please understand there are select plans that send insurance payments to you as the patient. If you have one of these plans, you may be subject to pay for services in full the day of your procedure(s). You will be reimbursed for these services by your insurance company when the claim we submit is processed. If insurance claims go past 60 days, you may be required to pay the full amount until claims are settled.**

☐ **Plan D**: If you do not have dental insurance, we are proud to offer an **In-Office Dental Plan**. Upon paying an annual fee, members will receive discounts on most dental services. Please see our receptionist for more details.

I understand and accept full financial responsibility for this account and for all dentistry performed upon my dependents in this dental office. I understand that it is up to me to confirm my insurance eligibility, waiting periods, and benefits. I understand that this office cannot guarantee my insurance status in any of these areas. Any insurance estimates given to me by this office are not a guarantee of actual insurance payment. Furthermore, I understand that if I do not pay my balance either in full at the time of service or through the agreed upon payment schedule, a monthly interest charge of 15% may be added to my balance. Non-payment may result in my account being turned over to an outside collections agency. If my account is turned over to collections, I will be responsible for all associated fees and costs.

_____ _____
Patient Signature Date

_____
Legal Guardian Name (if applicable)

_____
Legal Guardian Signature (if applicable)