

We believe in the importance of quality dental care, and we strive to provide the best dental treatment possible. Also, we understand the financial limitations that influence your choice of care. We want to assure you of our flexible approach to financing. We take VISA, MASTERCARD, DISCOVER, CHECKS, CASH, & CARE CREDIT (Ask about CARE CREDIT, if you are not familiar with it).

If you have dental insurance, we work with your insurance company and always try to maximize your coverage through meticulous detailing of procedures and interaction with your insurer. We even file your claim forms and we're available to answer any questions we can.

Please remember that insurance is considered a method of reimbursing the patient for fees to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and other pay a percentage of the charge. We are noticing more and more insurance companies are **NOT** covering **RESIN (WHITE FILLINGS)** and will **DOWNGRADE** to an **AMALGAM (SILVER FILLING)** fee. Please ask if you have any questions on this. It is **YOUR RESPONSIBILITY** to pay any deductibles, co-insurance, or any other balance not paid by your insurance company. The undersigned patient understands that payment either in full or partial co-pay as determined by your insurance benefit, is **DUE AT THE TIME OF SERVICE**. In the event that a patient is more than **90 DAYS PAST DUE**, the patient agrees to pay a finance charge of 1.5% per month. Failure to pay, you will be **RESPONSIBLE** for all collection costs, attorney fees, and court costs. We too, must balance our finances; we do ask that **YOU PAY YOUR PORTION** of the bill **AT TIME OF TREATMENT**.

We hope that you find this information useful. Rest assured that we are here to help make **QUALITY DENTAL CARE** obtainable for all. We look forward to working with you to achieve excellent dental health.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature
