Financial Agreement

Our fees are based on our cost of time, materials, personnel and expertise in providing a high level of quality dental care. We appreciate the opportunity to serve you and will do everything we can to provide you with the highest quality of dentistry that is both caring and comfortable. To facilitate this goal, we have developed the following financial options.

Payment Options

We ask for payment in full at the time of service. For your convenience, we accept **Cash, Visa, MasterCard, Money Orders and Personal Checks**.

We also offer financing through **Care Credit**. Care Credit offers certain interest free financing if the full balance is paid within that time period. They also offer low interest rates for extended payment plans. Some plans have a higher interest rate depending on your credit rating. If you are interested in Care Credit, an office representative would be glad to assist you.

Office Policies

* The appointment times are reserved exclusively for you. Please consider your appointment card as your confirmation. We understand that conflicts in schedules sometimes arise. If that is the case, **we ask that you give us a 48 business hour notice** so we can use that valuable time for patients who may be in need. We hope that you will help us in this issue so we can better serve you and our other patients. **A charge of $100.00 for missed appointments** will be applied if notice for a change of appointment was not received by our office 48 business hours before your appointment time.

* Treatment fees are estimates only and could be altered if your dental needs change. The patient will be notified of any change prior to treatment.

* Insurance *estimates* are estimates only. The patient is responsible for all treatment provided regardless of insurance involvement.

* **Interest will be charged at a rate of 1% per month on the balance if not paid within 90 days from the date of service**. This interest will be charged every month on each new balance until the account is paid in full beginning from the date of the last payment.

* **Any account 90 days past due will be sent to collections.** You will be responsible for the full amount plus any additional charges and fees if your account goes to collections.

* There is a **$45.00 charge for any returned checks (NSF)**.

By signing below, I agree to the above terms and agreements on services rendered to me and my dependents by *AnaBella Family & Cosmetic Dentistry*.

Patient or Parent/Guardian Signature: _____

Date: _____