

All Smiles Dental

Family & Cosmetic Dentistry
www.allsmilesflorida.com

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WRITTEN FINANCIAL POLICY

Thank you for choosing All Smiles Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from: Cash, Check, Visa, Mastercard, American Express or Discover Card

We offer a 5% courtesy to patients who pay in full with cash or check for treatment plans of \$3000 or more.

- NO INTEREST¹ Payment Plans² from Care Credit or Chase Health Advance

- Allow you to pay over time with NO INTEREST¹
- Convenient, low monthly payment plans² also available
- No annual fees or pre-payment penalties

All Smiles Dental requires payment **prior** to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.³ Please remember that a benefit plan is a contract between you and your company. We do our best to estimate the amount insurance will pay. In most cases a balance will be left after your co-payment is made and the insurance payment in full is received. **If the insurance payment has not been received within 60 days from filing, you will be liable for the account balance in full.** If no account payment has been received within 90 days, your account will be transferred to collections, accruing 33% delinquency fees at the time of transfer.

A fee of \$35.00 is charged for patients who miss or cancel more than 1 time in a calendar year without 48-hour notice. If a total of 3 appointments are cancelled, you will be required to pre-pay all future appointments.

All Smiles Dental charges \$30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and deserve.

X

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)