APPLE DENTAL
Family Dentistry

Policy of Payment for Dental Services

Thank you for selecting our office for your dental needs. To provide you with the best dental care and minimize the administrative cost, we provide you this financial policy. We are committed to providing you with the most positive experience in dental care.

We do not send the bill to your home for services rendered at the time of the appointment. We provide an extended payment plan option with **CARE CREDIT** upon credit approval.

1. We accept cash, checks, major credit cards, care credit, and most insurances. We accept assignment of benefits from insurances, as a courtesy to our patients. Patient is responsible for charges done on the date of services, whether the insurance company pays or not, and any differential balance not covered by the insurance (your insurance policy is a contract between you, the insurance company and your employer, our financial relationship is with you, not the insurance company).
2. We will provide you in most cases a **Pre-Treatment Estimate** with an estimate of your co-payment that will be due at the time of services. The copayment might be adjusted after the time of service depending upon final reconciliation with the insurance company (you are responsible for unpaid balance by the insurance company). Cash patients will pay the services rendered as it is on the estimate or will be notified prior to the treatment of any change treatment and the difference on the fee.
3. Large cases like crowns, bridges, partial, dentures, require ½ of the balance by the impression appointment. The other ½ or prior arrangement is due before the delivery appointment.
4. If an appointment is not canceled with a 24 hr notice, $25 will be charged to your account.
5. Balance over 90 days will be charged an interest charge of 1.5% per month (18% annually) plus applicable collection fees and may be turned to collection agency or to an attorney for collection. Collection fees, court cost, etc, will be added to your account.

Please contact us if you have any question about this financial policy. If you have any problems making timely payment to your account, please communicate to us so that we can assist you in the management of your account.

For Spanish translation please speak with the front desk manager.

Print Name (Patient or Responsible Party) _____

Signature (Patient or Responsible Party) _____

Date: _____