Charles S. McElfish, DDS

10 Hunt Club Plaza | Ridgeley, WV 26753 | (304) 726-4562

Written Financial Policy

Thank you for choosing Charles S. McElfish, DDS. 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. We believe that you are entitled to know the cost of our services before making a decision regarding treatment. If you have any questions regarding our payment policy or treatment fees please **ask us before you are seated for your appointment.**

PAYMENT IN FULL IS EXPECTED AT TIME OF SERVICE.

_____ _____

Patient Name (Please Print) Date

Payment Options:

For your convenience, we accept cash, personal checks, **MasterCard, Visa, Discover** or Convenient Monthly Payment Plans from **Care Credit (subject to credit approval)**

- **Allows you to pay over time**
- **No annual fees or pre-payment penalties**

Please Note:

- Charles S. McElfish, DDS requires payment prior to completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.
- For larger, more comprehensive treatment plans of $500.00 or more, a ⅓ deposit is required to secure your initial treatment appointment.
- A fee of $50.00 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.
- A fee of $30.00 is charged for returned checks.

If you have **Dental Insurance** to assist you with payment of your account and have provided us with your **complete** insurance information (company name, complete mailing address, policy and group numbers, etc.), we will file a **claim** on your behalf or provide you with the information that you will need to file the claim yourself.

If your insurance carrier will **assign benefits (PAY US DIRECTLY)** and we are filing your claim, we will accept your co-payment plus any unmet deductible as payment at the time of service. **Any additional amount unpaid by your insurance company will be DUE IMMEDIATELY upon receipt of your Explanation of Insurance Benefits (EOB).** However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

I have read the above payment policies and understand that I am responsible for all cost of my dental treatment and will settle my account as follows:

☐ **Cash** ☐ **Check** ☐ **MasterCard** ☐ **Visa** ☐ **Discover** ☐ **Care Credit**

PLEASE COMPLETE AND SIGN BELOW IF YOU HAVE DENTAL INSURANCE

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS (PLEASE INITIAL AND SIGN):

_____ I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION TO MY INSURANCE CARRIER RELATING TO MY INSURANCE CLAIM.

_____ I AUTHORIZE MY DENTAL INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO THIS OFFICE.

SIGNATURE OF PATIENT OR RESPONSBILE PARTY

_____