Dennis J. Schmidt, D.D.S.

Office Financial policy

Thank you for selecting us as your dental health care provider. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

- We work our financial arrangements accordingly to every case individually
- We require full payment of estimated patient portion at time of services.
    - With the exception of:
        - Crowns, bridges and other treatment that takes more than one visit to complete can be separated into two payments (½ at first visit and ½ at completion.
    - We accept the following credit cards:
        - Visa
        - MasterCard
        - Discover
        - American Express
        - Online Payments only @ www.Viewsmiles.com
    - We also offer outside financing through:
        - Care Credit

As a service to our patients, we will bill insurance companies for services and allow them 45days to render payment. After 60 days, you are responsible for the entire balance. **Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. Yours estimated portion must be paid at the time of service.** If you have any questions, our courteous staff is always available to answer them.

Account Balances

1.5% per month (18% per year) on the entire balance will be added to accounts past 90days. After 30days an overdue account letter will be sent out. If by 90 days there has been no contact with the office and no payment has been made, we may take a more aggressive action by turning the account over to a collection agency. Any fees associated with forwarding the account to such an agency will be added to your account. If there is a problem with paying the balance at the time of service or if there is a concern with an outstanding balance we encourage you, the patient, to please talk to us so we may work out something that works for both the patient and practice.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

Patient Signature: _____ **Date:** _____

Patient Signature: _____ **Date:** _____