Carolina Aesthetic Dentistry

Financial Policy

Our office is dedicated to providing you the best possible dental care. Payment of your bill is considered part of your treatment and it is important you understand our Financial Policy prior to any treatment.

Payment Policy

- ➔ Forms of payment accepted: Cash, Check, Visa, MasterCard, Discover, CareCredit, & ChaseHealthAdvance
- ➔ Payment is due at the time services are rendered. We do NOT accept payment plans.
- ➔ We reserve the right to cancel any patient's appointment if payment is not made in a timely manner.
- ➔ If dentures, partial dentures, crowns, onlays/inlays, bridges, or nightguards are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.
- ➔ The parent accompanying the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless financial arrangements have been made before appointment date.
- ➔ Returned Check Policy: Checks returned to our office from financial institutions are subject to a $25.00 returned check fee. Any future non-emergency appointments will be postponed until payment has been made good for the returned check.

Financially Responsible Party

Person Financially Responsible for Account: _____ Relationship to Patient: _____

Primary Phone # : _____ Secondary Phone # : _____

Address (*if different from patient*):_____ City_____ State____ Zip Code _____

For Patients with Dental Insurance

- ➔ Your insurance policy is a contract between you and your insurance company and our office is not a party of the contract. **It is your responsibility to be aware of your policy.**
- ➔ Our office files primary and secondary insurance as a courtesy and it is your responsibility to provide all current and complete insurance information at the time of service. If you have secondary insurance, please ask for a copy of our Secondary Insurance filing policy.
- ➔ In the event your primary insurance company has not paid in full within 60 days, the financially responsible party will receive a bill for the account balance. Our practice charges a usual and customary rate for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- ➔ **ALL insurance co-insurance and deductibles must be paid at the time of service. Please understand co-insurance are estimates and may change based upon insurance payments.**

Insurance Information

Name of Insured _____ Relationship to Patient _____ Date of Birth of Insured _____

Social Security No. of Insured _____ Employer of Insured _____ Date Employed _____

Primary Phone # : _____ Secondary Phone # : _____

Insurance Company _____ Group No. _____ Employer No. _____

Insurance Co. Address:_____ City_____ State____ Zip Code _____

I, _____, understand and agree to uphold these policies. I agree to provide the office with my correct insurance information and to pay my portion of my account at time of service.

_____ _____

Signature Date