ARTISAN DENTAL
Cosmetic, Sedation and Implant Dentistry

# Financial Policy

**Thank you for selecting us to help take care of your dental health. We are committed to having your treatment be a positive and transparent experience. It is our belief that all people who entrust their oral health to us want and deserve the best dental care that we are capable of providing. Please understand your financial obligations are considered part of your treatment. Our purpose in providing you this financial information is to acquaint you with our policy for our mutual benefit. We will give you an estimate of costs required in advance of treatment so that you can come prepared for each visit. Please read the following and sign before being seen.**

**1. Payment For Service**: Full payment is due at the time of service. A 5% cash courtesy will be given when services are paid for in full prior to the day of treatment by cash or check for services totaling $1000 or more. This option is not available to patients who pay with payment options that include third party financing through Care Credit or Lending Club. Other payment options include a 3% Prepayment courtesy will be given when services are paid for in full prior to the day treatment is scheduled. Applies to any personal Credit Card (Visa/MasterCard/American Express or Discover) for services totaling $1000 or more. If payments are made in advance for future services that are not rendered, a refund will be issued minus any lab fee that has occurred. All lab fees are final and non-refundable.
The following applies to those patients with insurance;
- We attempt to verify coverage on your behalf. However, the information that we receive is not a guarantee of benefits or payment by your plan.
- Dental insurance is a contract between YOUR employer and THE dental insurance company. The benefits that you will receive are based on the terms of the contract that were negotiated between your employer and the dental insurance company, NOT with your dental office.

**2. Financially Responsible Party**: Any minor patient must be accompanied by a parent or guardian for all appointments unless written consent is provided. The adult accompanying the minor is responsible for payment. The person(s) providing payment in lieu of the patient's own compensation agrees to the charges of services rendered. Compensation provided from another person(s), by the patient is agreed upon between the patient and financially responsible.

**4. Past Due Account Fees**: There is a $25 fee charged on all returned checks. Account balances older than 30 days are subject to a finance charge of 1.5% per month plus a monthly billing fee of $5.00. Any balance older than 90 days will be forwarded to "Collections" and subject to additional collection fees, including, but not limited to, attorney's fees, court costs, etc.

**5. Consent for Treatment**: I hereby give consent to the dentist and/or his/her designee(s) for the performance of any diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I further authorize the performance of all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me. I understand that no guarantee or assurances have been made as to the results that they may be obtained.

**My signature below acknowledges that I have read and understand the above information and agree with its contents.**

(Print Name)

_____ _____
(Signature of Patient, Parent, or Guardian) (Date)