

In order to enhance communication and promote understanding regarding our Financial Policies, please read through the following information. Our Office Manager is happy to address any questions you may have about these policies.

- ❖ **Insurance:** Beautiful Smiles is happy to bill your primary and secondary insurances as a *courtesy* for our patients. Each patient (or guardian for minors) remains responsible for the cost of services rendered. Your dental benefits are based upon a contract between you, your employer (where applicable), and your insurance company. ***If you have questions regarding your dental benefits, please contact your employer or insurance provider directly. Insurance plans are only meant to assist you with the investment in your dental care. They very rarely pay for the total cost of treatment.*** While our staff will verify insurance coverage and *estimate* your costs for the procedures to be performed, ***this is not a guarantee of payment by your insurance.*** If we do not receive payment from your insurance within 60 days from the date of service, you will be responsible for paying the remaining balance of your treatment and collecting your benefits directly from your insurance provider. While this rarely occurs, it is important for you to recognize that your insurance is a legal contract between YOU, your employer, and your insurance provider. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.
- ❖ **Financing:** For patients interested in a payment plan, we offer financing through Care Credit and Citi Health. Please consult with our Patient Coordinator prior to your treatment if interested in this payment option. Individuals are subject to approval by lender.
- ❖ **Appointment Deposit/Patient Payment:** To reserve an appointment for treatment, a deposit equaling 50% of estimated patient portion ***may be required*** at time appointment is scheduled. The remaining patient portion is due upon arrival for appointment prior to services being rendered. Beautiful Smiles accepts cash, checks, Visa, MasterCard, and Discover Card.
  - **Hygiene Appointments:** Patients who fail to cancel or reschedule a hygiene appointment at least 48 hours in advance will be required to provide a \$35 deposit to reserve future hygiene appointments.
  - **Family Appointments:** For appointments in which three or more family members are scheduling on the same day, a minimum \$35 deposit is required to hold this large block of time.
- ❖ **Missed/Rescheduled Appointments:** Notice to cancel or reschedule an appointment is required at least 48 hours in advance so we have the opportunity to offer your appointment time to another patient needing treatment. Monday appointments must be canceled or changed by 5 pm on Thursday. If appropriate notice is not given, patient will be charged a \$75 cancellation fee or forfeits their appointment deposit, whichever is larger.
- ❖ **Refunds for Unfinished Treatment:** Refunds are not available once a patient has started treatment.
- ❖ **Credits on an Account:** If an insurance company pays more than anticipated for the patient, we will issue a credit on the patient's account to be applied towards future treatment. Credit refunds are available upon request. All outstanding insurance payments must be received before a refund will be issued.
- ❖ **Minor Patients:** A parent/legal guardian must accompany each child, under the age of 18, to their first visit. In addition to the patient, the person who brings the child to the office and signs the consent form shall be financially responsible for the child's account.
- ❖ **Family Accounts:** Spouses and all legal dependents will be linked together in a family account for financial and insurance purposes unless otherwise requested.
- ❖ **Account Balances:** All payments must be made by their due dates. A \$25 fee will be assessed for any check returned by a bank due to insufficient funds. Beautiful Smiles will not provide further treatment until a delinquent account is paid in full. Patients will be charged interest at the rate of 1.5% monthly on any balance over **45 days**. If any balance becomes 60 days past due, the account will be assessed a \$35 late fee and transferred to a third party (attorney or collection agency) for collection. Should additional means of collection become necessary, all costs of collection, including attorney fees, court costs, collection agency fees, and any other costs or fees permitted under Indiana law will be added to your account balance.

After reviewing, please sign to indicate you received and agree to comply with our Financial Policies. Upon receipt of your signed form, we will proceed with your scheduled appointment.

Patient Name: \_\_\_\_\_

Financially Responsible Party (if different): \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_