Perfect Smile Dental Spa

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Thank you for choosing us for your dental needs. We are committed to providing you with excellent care and successful treatment. Just as we want to have clear communication and complete understanding of any dental treatment, we want the same clarity regarding finances. Please read and sign the following statement of financial policy. Please feel free to ask if you should have any questions regarding this policy.

Payment: Payment is due at the time services are rendered unless prior financial arrangements have been made. We offer the following options as a method of payment:

1. We accept ***Cash, Visa, MasterCard, American Express*** *and* ***Discover*****.**
2. **½ & ½ Plan**: Half of the payment is due at the first treatment appointment & the remaining half is due at the final treatment appointment (for treatment such as crowns).
3. ***Care Credit*** with No Interest up to 12 months or a low interest of 14.9% up to 60 months.
4. ***Dental Fee Plan*** with low monthly payments.

Dental Benefits: We will gladly process your insurance claim; estimate your deductible and the portion not covered by your insurance***. Please note that your insurance policy is a contract between you and your insurance company and as a provider, we are not party to that agreement.*** The quality of insurance policies varies greatly, therefore we can estimate your coverage in good faith but cannot guarantee coverage due to the complexities of dental insurance contracts. The estimated amount not covered by your insurance is due at the time of treatment and may be paid by any one of the options listed above. Our estimates are subject to final payment received by the insurance company; therefore, the amount due to our office is subject to change. By law, insurance companies must notify us in writing or pay the claim within 30 days. We will notify you within 45 days to contact your insurance company if payment has not been received. Please note that we will only allow 60 days for a dental claim to process. If payment is not received within 60 days, the outstanding balance will be your responsibility and must be paid in full.

Minors: Payment for services for the treatment of minors can be made by cash, check, credit card or Care Credit and is the responsibility of the adult accompanying the minor.

Divorce: We look to the adult who has brought the child in for the appointment to be responsible for payment of services which are rendered to the child. We also expect parents to be able to work out payment arrangements with each other and not to involve our office staff in any disputes that may arise.

Missed Appointments: Once a dental appointment has been made, please keep in mind that this time has been reserved especially for you. ***We require a full 48-hour notice for any appointment changes or cancellations. We reserve the right to charge $50 for oral hygiene appointments and $75 for periodontal treatment scheduled with our Hygienist when a 48-hour notice is not provided. There will be a charge of $150 per hour for appointments scheduled with our Dentists that are cancelled or rescheduled without a 48-hour notice***. Please understand that messages left on voicemail for appointment changes or cancellations will not be accepted and you will need to speak with a staff member during regular business hours. Pre-payment for all dental services will be required after 2 missed appointments or cancellations without adequate notice (48-hours). Prices subject to change.

Service Charges: The ***policy of this office is to charge 1.5% monthly*** (18% annual percentage rate) or a billing charge/late fee which will be applied to all accounts over 60 days past due. We will charge $35 for any returned checks.

Collections: In the event that we need to make use of an attorney or collections agency, all pertinent information will be sent to that service. Fees incurred to collect payment will be billed to and payable by the patient's account holder.

Financial Consent: ***By signing this notice of payment policy, I am acknowledging that the policy has been read in its entirety. ***I also understand that payment of this account is my full responsibility***, regardless of the amount my insurance company reimburses before or after payment is made.

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Patient/Parent/Guardian Signature Date