COMPLETE HEALTH DENTISTRY
OF THE EMERALD COAST

Financial Policy

Thank you for choosing Complete Health Dentistry of the Emerald Coast as your dental care provider. We are committed to your treatment being successful. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

Our office has a Zero balance policy. Payment is expected when services are rendered. Unless a payment arrangement has been made ahead of time. (Signed agreement with payment on file) Please ask us if you are interested in learning about third party financing, which may allow you to finance your treatment in low monthly payments. **As a courtesy to all of our insured patients**, we will file your dental insurance claim forms for reimbursement to be made directly to you.

Should a balance accrue on the account, which a payment arrangement has not been made, a statement will be sent and payment is to be made, in full, by the date on the statement. Amount due and not paid in full within 30 days will be charged interest at a rate of 1.5% per month in addition to a $10.00 monthly billing fee per statement.

A returned check fee of $40.00 (subject to change as bank fees increase) will be added to your account for any returned check. Before we accept another payment by check, the $40.00 fee plus full payment for the check that did not clear must be paid in cash, or by Visa, Mastercard, Discover or American Express.

As dental providers, **our relationship is with you**, not your insurance company. Your treatment plan is individually tailored, and is not based on your dental insurance benefits or lack of benefits.

I understand and accept the financial and the dental insurance policies listed above and have had any and all questions answered to my satisfaction. I agree to pay for all treatment at time of service, unless a payment arrangement has been previously made, to avoid any additional fees. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees and I agree to pay such charges in full.

(Patient or Legal Guardian)

Printed Name: _____

Signature: _____

Date: _____

(If signed by legal Guardian) Patients Name: _____