WASHINGTON SQUARE DENTAL GROUP, P.C.

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FINANCIAL POLICY & CREDIT CARD AUTHORIZATION FORM

Thank you for choosing **Washington Square Dental Group, P.C**.. Our primary mission is to deliver the best and most comprehensive dental care available. Our fees are based on the quality materials we use and the time, effort and skill required in performing your treatment. They are reasonable and customary to our area. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering payment options. We accept cash, check, Visa, MasterCard, American Express or Discover Card. For extensive cases/treatment we offer usage of a convenient Monthly Payment Option from CareCredit Healthcare Credit Card. This option allows you to pay over time with no annual fees or pre-payment penalties

Payment is due at the time services are rendered unless alternate arrangements have been made in advance with the office manager. We require an initial deposit of at least 50% for any treatment involving a laboratory.
For patients with PPO dental insurances, as an out of network provider with all plans except for Delta Dental Premier, we are happy to work with your carrier to maximize your benefit and directly bill them electronically for costs of your treatment. Your *estimated* copayments are due on the date of service.

For <u>all</u> patients with dental insurance, we require a credit card to be kept on file for any balances unpaid by the insurance. Once we receive payment from your dental insurance carrier, if there is any balance remaining, we will charge the credit card on file.
While most PPO dental insurances do directly reimburse the dentist, some may only remit payment to the patient. In this case, the patient is responsible for providing payment in full to the office and we will file a claim on your behalf to your carrier for reimbursement.

Should any balance remain unpaid after 60 days or should you violate the terms of your payment agreement, we reserve the right to refer your account to our collection agency. Any fees associated with the collection of these delinquent accounts will be the direct responsibility of the patient.

Should you need to cancel/ reschedule an appointment, kindly give the office at least 24 hours notice (48 hours notice for an appointment length of two hours or greater) or a cancellation fee of $50 or more, depending on length of appointment, may be applied to your account. There will be a $30 fee for any returned checks.

Upon any credit card charges processed, please send me a courtesy notification by:

(CHECK ONE) _____ Phone _____ E-Mail _____Mailed Receipt

<u>NOTE</u>: We do not wait for a verbal, text or email approval, as this form serves as the authorization.

Patient Name: _____

Cardholder Name: _____; Relationship: _____

Billing Address: _____

Card #: _____ Exp Date: _____/_____ Sec Code: _____

Cardholder Signature: _____ Date: ____/____/_____

*Is this an employer funded HealthSavings or Flexible Spending card? _____YES _____NO

Should this card be used for all family members? _____YES _____NO