WASHINGTON SQUARE DENTAL GROUP

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FINANCIAL POLICY & CREDIT CARD AUTHORIZATION

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 within reasonable and customary for 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.

For patients with PPO dental insurance, 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.

Please select your preferred billing option from the 2 choices below:

☐ I choose to leave my credit card on file with Washington Square Dental Group 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.

☐ I choose not to leave a credit card on file with Washington Square Dental Group, therefore I will pay in full at the time of treatment rendered. I will submit the paperwork on my own and be reimbursed directly from my insurance (if applicable)

Payment is due at the time services are rendered unless alternate arrangements have been made in advance with the office manager. We require a down payment of at least 50% for any treatment involving a laboratory. Should any balance remain unpaid after 60 days or 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 or 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.

Patient Name: ____

Patient Signature: _________________________________ Date: ____/____/_______

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Cardholder Name: _________________________ Relationship to patient: __________

Billing Address: ____

Card #: ____ Exp Date: _____/______

***Is this an employer funded HealthSavings or Flexible Spending Card? _________Yes _________No

Should this card be used for all family members? _______Yes _________No

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

(CHECK ONE) ________Phone ________E-Mail ________No Receipt Necessary

Note: We do not wait for a verbal, text, or email approval, as this form serves as authorization