GRACE DENTAL
FAMILY & COSMETIC DENTISTRY

Office Payment Policy

All emergencies and first appointments are to be paid at the time of the appointment. All fees are to be paid the time the service(s) are performed. In the case to extended treatment, payment of one-half at the first appointment and the balance to be paid by the time treatment is completed.

Methods of payment:

- **Cash**
- **Check**
- **Insurance**
- **Care-Credit (our in office financing)**
- **Arrange your own credit union or bank financing**
- **Credit Cards (Master Card, Visa, Discover, American Express)**

Most insurance is accepted by our office, however all secondary insurance must be filed by the patient. When utilizing insurance, the estimated amount of insurance will be calculated. The amount the patient pays will also be calculated and this payment is due when treatment begins. If there is any over or under payment regarding insurance, an adjustment will be made. The patient is responsible for any amount the insurance does not cover.

Our office understands that some people are unable to pay cash at the time of their treatment. Therefore, we offer an extended monthly payment plan. This monthly payment plan does not require payment now, nor the use of your bankcard. Processing your application does not take long. Please ask the front office for details.

We are only able to offer the above terms. If an account balance is not paid in a timely manner, it will be turned over to our collection agency. The patient will be responsible for any billing, finance or collection fees, which may occur. We are most happy to work out any reasonable arrangements with our patients within the credit framework that we have established.

We believe that communication is vital in order to establish a mutual understanding. This is the foundation of a long-term health care relationship, based on trust, honesty, and fairness. If at any time you have questions regarding fees or treatment, please feel free to talk to us about them.
By signing this policy, I understand that I am ultimately responsible for payment for services rendered, including reasonable attorney's fees and cost of collection in the event of default.

Name_____ Date _____
(Patient/Guardian signature)