FAIRMONT DENTAL ASSOCIATES

GENERAL AND COSMETIC DENTISTRY
COMPLETE ORAL CARE CENTER FOR YOU AND YOUR FAMILY

INSURANCE AND FINANCIAL POLICY

We do understand your dental needs and concerns. Financial restriction should not be a reason for you to make the right decision about your oral health. To help our patients in making the right health decisions we offer many affordable financial options to pay for your dental treatment in your journey to live your life healthy and happy.

Cash or Check:

A courtesy discount of 10% is given when complete procedural fees in excess of $300 are paid in full by cash or electronic check on or before the day of service. Not to be combined with any other courtesy discounts.

Credit Card:

We accept American Express, MasterCard, Visa, & Discover.

Our Financing Options:

We can make arrangements for a monthly payment plan with Care Credit but this must be accomplished prior to the actual procedure.

Examples include:

- 0% Short term payment plans can be prearranged in-office.
- Interest free financing for up to 12 months.
- Long term financing for as little as $69/month (with approved credit)

Application for Care Credit can be filled out online or by our front desk staff and you can instantly get the response in seconds Please feel free to call us if you have any question or concern about our financing option.

Insurance Policy

We are always willing to help you in getting the maximum benefit out of your insurance plan. We do accept all the insurance plans. We would also like to take this opportunity to help you in

understanding that your dental plan is a form of compensation provided by your employer. You can expect the carrier (insurance company) to reimburse you for a portion of our fee. That portion is determined by the contract between your employer and the insurance company. The higher the premium paid by your company, the more generous the reimbursement.

We will make every effort to assist you with any dental insurance benefit questions and will help to make the payment process simple for you. Although we are not a party to the contractual arrangement with your insurance company, we do want to help you receive the maximum reimbursement to which you are entitled. We have relationships with many insurance companies, and can guide you to get the most for your money.

As a convenience to you, we will help you process your insurance claims in order for you to receive this maximum benefit. We will also gladly provide dental x-rays and a written diagnostic report should your insurance company have any questions about the services provided.

Please remember you are fully responsible for all fees charged by this office regardless of your insurance coverage. Any portion not expected to be covered by these benefits is the ***responsibility of the patient and due at the time the service is rendered***. This amount will include deductibles and co-payments. If benefit amounts are less than expected, you will be billed for the difference and payment is due within 10 days. We will send you a monthly statement. Most insurance companies will respond within four to six weeks. Please call our office if your statement does not reflect your insurance payment within that time frame. Any remaining balance after your insurance has paid is your responsibility.

There is a $35.00 charge for returned checks. If a check is returned and not paid within 7 days of return date, legal action may be taken for collection. Any costs associated with collection of returned checks will be assumed by you.

In the event your account becomes delinquent, you will be responsible for collection fees, attorney fees and court costs.

The parent accompanying the child/minor on the day of service will be considered the responsible party. We will gladly provide you with copies of statements, which you may need to provide the other parent for reimbursement.

At all times, you can be confident that we will always provide you with our best without regard to the limitations imposed by your insurance coverage. To do otherwise would violate our contract with you----a contract we feel morally obliged to honor.

This is to certify that I have read the financial policy and have been given the chance to ask any question or concern. I will be held responsible for the financial obligation that I incur according to the guidelines of this policy.

Signature of Responsible Party _____ Date _____
**Patient, Parent, or Legal Guardian*