Financial Policy

- **Insurance Benefits:** We are happy to complete and submit your claims to your insurance company on your behalf. Every effort will be made to collect the maximum benefits allowed from your insurance company. However, your insurance is a contract between you and your insurance company. We ask that you read your policy carefully. Some or all of the services we provide may not be a covered benefit. We cannot guarantee the payment estimate that is quoted nor do we have information on benefits used at any other dental offices within your plan year. Any balance remaining after your insurance pays is your responsibility and due within 15 days of billing.
- **Payment:** Our policy is to collect FULL PAYMENT at the time of service. If insurance benefits apply, patient CO-INSURANCE and DEDUCTIBLES are due at the time of service, unless other arrangements are made. If complete payment cannot be made, we accept payment through third party financing such as CareCredit. 18% APR on the unpaid balance will be charged on accounts exceeding 30 days.
- **Minor Patients:** The adult accompanying the minor (18 and under) is responsible for payment of the services provided. A parent or legal guardian MUST accompany the minor unless prior arrangements have been made.
- **Missed appointments:** For the courtesy of other patients that are waiting for appointment times, please be aware that we require **48 business hour notice** to change or cancel an appointment to avoid a fee of **$50 per half hour** of time scheduled.
  I prefer to by contacted via: [ ] Phone [ ] Email [ ] Both Initial: _____
- **Payment Options:**
  1. We accept: VISA, MASTERCARD, AMERICAN EXPRESS, CASH OR CHECK
  2. Healthcare Financing: We accept CareCredit
  3. Senior Citizen Discount: For our senior citizen patients with no insurance, we offer a 10% discount off our house fees.

CONSENT FOR CARE:

This is an agreement between Redmond Family Smiles, as a provider of professional services and creditor, and the Patient/debtor named on this form. By reading and signing this document, you are agreeing and accepting this policy in full.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION; ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION; I UNDERSTAND AND AGREE TO ALL POLICIES OF REDMOND FAMILY SMILES.

Print Name_____ (patient/subscriber, and- if minor- guardian)

Signature_____**Date**_____