

# Financial Options Agreement

*We require payment in full at the time of service, and we have multiple payment options to assist you with timely payment. Any deviation from this agreement must be approved/arranged by the office manager or Dr. Josh.*

Patient's Name \_\_\_\_\_ Parent's Name \_\_\_\_\_

*I choose the following method of payment for dental care performed for my immediate family and my child/children:*

## I Have No Dental Insurance:

- I elect to pay by cash \_\_\_\_\_ check \_\_\_\_\_ Master Card \_\_\_\_\_ Visa \_\_\_\_\_ Discover \_\_\_\_\_ American Express \_\_\_\_\_ on all visits as treatment progresses.
- I prefer to use your in-office finance plan (Care Credit) and to make smaller monthly payments over an extended period of time. I realize that on approved credit, I will qualify interest free for 3 to 6 months. For larger balances over \$1000.00 I may qualify for an extended finance payment plan. (This service is available through our office but will be billed by Care Credit directly.)

## I Have Dental Insurance:

Name of Insurer \_\_\_\_\_

- I elect to pay my deductible and/or patient portion on each visit as treatment progresses by cash \_\_\_\_\_ check \_\_\_\_\_ Master Card \_\_\_\_\_ Visa \_\_\_\_\_ Discover \_\_\_\_\_ American Express \_\_\_\_\_. I also realize that all balances left after insurance pays are due within 25 days of receiving Pediatric Dentistry's statement.
- I prefer to use your in-office finance plan (Care Credit) and to make smaller monthly payments over an extended period of time. I realize that on approved credit, I will qualify interest free for 3 to 6 months. For larger balances over \$1000.00 I may qualify for an extended finance payment plan. (This service is available through our office but will be billed by Care Credit directly.)

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Responsible Party/Legal Guardian

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## Cancellation/Broken Appointment Policy

To bring our patients the highest level of service, it is important to maintain a strict respect for your time and ours. We work diligently to see our patients at their appointment times. We know you respect this and strive for the same goal. We have a waiting list of patients wanting earlier appointments than we were able to offer them. **Consequently, we request a 24-hour notice if you need to change your appointment for any reason.** This enables us to accommodate all our patients. If you have 2 broken appointments and provided no 24-hour notice, you will be subject to a pre-payment before scheduling your next appointment. The pre-pay fee will be \$35 for a routine cleaning, \$50 for a restorative visit, and \$70 for a sedation appointment (please see our separate "Instructions for Sedation" sheet for further information on our sedation broken appointment policy). *This pre-pay fee is not covered by your insurance.* 3 or more failed appointments could result in your family's dismissal from the practice. Your cooperation enables us to accommodate all our patients' needs by offering the cancelled appointment to others. We understand that many unexpected things occur; however, please assist us in offering the best service and care to all our valued patients.

Furthermore, keeping your child's dental appointments is in the best interest of your child's health. Remember that the pain medication and antibiotics only relieve the *symptoms* of dental decay. Progression of the decay may result in abscess formation possibly even to the point of requiring hospitalization. We want to help your child before this happens. Thank you for your cooperation!

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Responsible Party/Legal Guardian