FINANCIAL POLICY

This is an agreement between Smiles On State Street and the patient. By executing this agreement, you are agreeing to pay for all services that are received.

Payments: Payment for services are expected at time of service unless we approve other arrangements in writing prior to your appointment. Accounts are considered past due if not paid by the **15th** of each month.

Payment Option:

A: You may pay your portion at time of service by Cash, Check, Visa, MasterCard or Care Credit.

B: On extensive treatment (crowns, bridges, etc.) you may pay 50% of your portion at the preparation date, and the balance at the delivery date.

Finance Charge: A finance charge may be imposed on each item of your account which has not been paid within **30 days** of the time the item was added to your account. The FINANCE CHARGE will be computed at the rate of **18%**.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your insurance company as a courtesy to you. Although we will estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree and understand that YOU are responsible for benefits, payments, or any claim inquiries including yearly maximums.

Returned Checks: There is a fee of **$50.00** for any checks returned by your bank.

Missed Appointment Fee: We require at least 24-hour notice in order to change or cancel any appointments. There will be a $50.00 fee for all appointments missed or canceled with less than 24-hour notice.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect the debt. If we have to refer your account to a collection agency, you agree to pay a minimum fee of **$50.00** in addition to the balance on the account.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient Name: _____

Responsible Party: _____ Date: _____