Financial Policy

Thank you for choosing Thornville Dental, Dr. Chase Smith. Our primary mission is to deliver the best and most comprehensive care for each patient. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. If you have any questions regarding our financial policy, please do not hesitate to speak with our Financial Coordinator. We will be sensitive to your financial circumstances within the framework of sound business practice.

Payment Options:

- Cash or Check
- Visa, Mastercard, Discover and American Express
- Care Credit -allows you to pay over time with interest deferred

Please Note:

- Payment is required prior to the completion of your treatment
- A broken appointment fee of **$35** is charged for patients who miss or cancel an appointment with less than 2 business days notice.
- A fee of **$36** will be charged to your account for returned checks
- A billing fee of **$3/month** will be charged once an account is more than 60 days delinquent
- A finance charge will be imposed on past due balances at the Periodic Rate of **1 ½% per month** for a total **Annual Percentage rate of 18%**

Dental Insurance

-For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill your primary insurance for reimbursement for your treatment.

-We will provide you with an estimate and ask that you pay your portion at time-of-service.

-If the insurance company has not paid your claim within 60 days, the total balance will automatically be transferred to your account for payment.

I understand and accept *the financial and the dental insurance policies listed above and have had any and all questions answered to my satisfaction.* ***I agree*** *to pay for all treatment in a timely fashion as described so as to avoid any additional fees.*

I hereby authorize *my insurance benefits to be paid directly to Thornville Dental. I realize that I am responsible to pay for any deductible(s), my co-insurance portion and any non covered services.* ***I understand*** *that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by insurance and* ***I agree*** *to pay such charge in full. I* ***hereby authorize*** *the release of pertinent medical/dental information to the insurance carrier. This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.*

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Patient or Guardian Signature Date

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Patient Name (please print) Staff Initials