Lowell Dental Care

OFFICE POLICY AND FINANCIAL AGREEMENT

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility before treatment begins. The following is a statement of Lowell Dental Care's office policies and financial agreement. We ask that you please read, agree to, and sign the agreement before any treatment is rendered.

Payment Options

We want to make dental treatment fit into each of our patients' individual lifestyle. Therefore, we offer the following financial arrangements.

1. Visa/MasterCard/American Express/Discover
2. We are pleased to offer a choice of interest deferred extended payment plans through our financial lender **Care Credit.**
3. Other: For patients who would like to make payments in advance toward treatment, this can be arranged with the financial coordinator prior to appointment.
4. **Patients without Dental Insurance**: **Payment for dental services is due at the time of treatment**, therefore, we offer a 5% discount for payments made by Cash or Check for services over $500.00.
5. **Patients with Dental Insurance**: **Estimated portion not covered by insurance is due at the time of treatment**. *Please note: We are a third party to the contract and your insurance company is not obligated to share your confidential policy information with us. There are constant changes being made by your employer and insurance carriers to your coverage, deductibles, and annual maximum. These changes are not being shared with us. Therefore, it is difficult for us to know exactly what your policy covers and we can only estimate what they are going to pay. ______________________ (initial)

Cancellation Policy

If you are unable to keep an appointment for any reason, we ask that you kindly provide us with a minimum of **2 business days notice.** All changes in your scheduled appointment must be handled during our regular business hours, or a $50 fee may be charged to your account. This courtesy on your part will make it possible for us to give your appointment time to another patient who will be able to utilize that time. _________________ (initial)

Delinquent Accounts

After 90 days, all accounts that are not paid in full may be sent to a third party collection agency. Any accounts turned over to collections will be accessed a collection fee. ___________________ (initial)

By signing below, I have read, understood, and agree to the above-mentioned Office Policies and Financial Agreement

____

Patient Name **Date**

____

Patient Signature (parent/guardian signature if minor)

Please list Insurance Information Below

Name of Subscriber: ____

Subscriber SSN: ________________________________

Subscriber Member ID: ___________________________

Subscriber Date of Birth: __________________________

Subscribers Employer: ____

Group # ______________________________

Relationship to Subscriber (please circle): Self Spouse Child Other

Name of Insurance Company: ____

Phone number of Insurance Company: _________________________________

Name of Subscriber: ____

Subscriber SSN: ________________________________

Subscriber Member ID: ___________________________

Subscriber Date of Birth: __________________________

Subscribers Employer: ____

Group # ______________________________

Relationship to Subscriber (please circle): Self Spouse Child Other

Name of Insurance Company: ____

Phone number of Insurance Company: ________________________________