www.SmileDentalFL.com

**Smile Dental**
**11500 University Blvd. Suite 101**
**Orlando, FL 32817**
tel. 407-737-6464
fax 407-386-9088

# THE FINANCIAL POLICY

**GENERAL**

Thank you for choosing our practice as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read, and sign prior to treatment. All patients must complete our Information and Insurance form before seeing the doctor. FULL PAYMENT IS DUE PRIOR TO TREATMENT. WE ACCEPT CASH, VISA, MASTER CARD and CARE CREDIT. **WE DO NOT ACCEPT PERSONAL CHECKS OR AMERICAN EXPRESS. NOTE: REFUNDS, PROCESSING FEE WILL APPLY FOR CREDIT CARD & OR CARE CREDIT PAYMENTS.**

**REGARDING INSURANCE**

Fees are estimates only, are valid for 30 days from the date shown above and are subject to revision. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment.

**REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER**

All ESTIMATED portion and deductible are due prior to treatment. In the event that YOUR insurance coverage changes to a plan where we are non-participating providers, refer to above paragraph.

**USUAL AND CUSTOMARY RATES**

Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**ADULT PATIENTS**

Adult patients are responsible for full payment at time of service.

**MINOR PATIENTS**

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved; Visa/MasterCard, or payment by cash or check at time of service has been verified.

**INTEREST**

We reserve the right to charge interest in the amount of 18% per annum as provided by state law.

**COLLECTIONS**

If you're insurance company doesn't pay for any services rendered, you will be responsible for the entire balance. If this balance is not paid within 120 days the account will be sent to an Outside Collection Agency.

Thank you for understanding the Financial Policy. .

# BROKEN APPOINTMENTS

Office hours are made by appointment and we do value your time. Our office strives to provide a pleasant and timely dental experience for each and every patient, and we expect our patients to display the same respect.

We make our best effort to confirm appointment 24 – 48 hours in advance. However,

confirmation calls are a courtesy. Missed calls, disconnected phones, wrong e-mail address, and other circumstances where you do not receive a confirmation call do not excuse a missed appointment. If you cannot make an appointment, we require at least 24 hour notice, not including weekends and holidays. Cancelation must be made with a staff member during regular business hours. There will be a charge of **$25** for the hygiene appointment and **$50** for the doctor appointment. **Message left on the voice mail are not considered prior notification. We ask that you arrive 15 minutes prior to your scheduled appointment.** Please help us serve you better by keeping scheduled appointments.

## INFORMED CONSENT FOR TREATMENT

We will provide you with a treatment plan to meet your specific dental needs. We design the treatment plans with several goals: prevention of dental disease, minimal change to healthy tooth structure and gum tissue, and restoring teeth with materials what will last the longest with the fewest future problems. All options will be explained to you along with the advantages and disadvantages of each treatment. It is your responsibility to complete treatment and follow recommended maintenance schedules. The failure to proceed with your treatment plan in a timely manner may result in adverse effects on your dental health. Further treatment for the involved teeth, supporting tissues, adjacent and opposing teeth, muscles or joints will be based on our standard professional fees.

By signing this form, I am giving the doctor permission to perform a full comprehensive exam and recommend treatment.

## SIGNATURE ON FILE

I hereby authorize payment directly to Smile Dental otherwise payable to me. Smile dental and its staff are authorized to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the terms of coverage of the policy or contract, in force on this date only, or for two years, which ever is shorter, unless revoked by me at an earlier date.

I, {Patient Name} , have viewed a copy of this office's financial policy, broken appointment, informed consent for treatment, & signature on file.

_____ Date:

Patient Signature (Parent/Guardian for minor child)