

## Payment Methods

<input type="checkbox"/> Personal Credit Cards Visa, MC, AMEX, Discover	<input type="checkbox"/> Prepayment We are happy to offer an 8% discount when prepaid in full upon scheduling (cash or check)	<input type="checkbox"/> Personal Personal check or cash
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**Financing Option**

We are pleased to offer two financing options which are administered through our financing partner:

CareCredit (\$300-\$25,000) No Interest Payment Plan (3, 6, 12 or 18 months)

CareCredit (\$1000-\$25,000) Extended Payment Plan (24-60 months) \_\_\_\_\_% interest

Please see our administrative staff for detail and credit application

In the event of a returned check, an additional \$25.00 processing fee will be charged. We cannot accept a personal or business check to replace NSF items. Payment for the amount plus the \$25.00 must be paid in cash, cashiers check or money order. The NSF fee is charged for any reason such as insufficient funds or closed account.

**Non-Insured Patients Financial Policy:** For non-insured patients, payment is due at the time of service with any of the above payment methods.

*I authorize the release of any information necessary to the process of dental claims and billing of my account. I also authorize my insurance company to pay directly to this office for fees charged for services rendered to me or my dependant(s).*

\* For seniors 62+ years old without insurance, we offer a 10% courtesy discount for treatment when it is paid in full on or before the treatment date. This offer does not extend to payment plan accounts.

**Consent:** I have fully read and understand the above. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my or my dependant's dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by use of anesthetics, sedatives and other medication as necessary. I fully understand that I can ask for a complete recital of any possible complications. ***I agree to the terms of this document and agree to be responsible for payment of all services rendered on my and/or my dependant's behalf.***

\_\_\_\_\_  
 (Signature of Patient/Responsible Party)

\_\_\_\_\_  
 (Date)

\_\_\_\_\_  
 (Witnessed By)

\_\_\_\_\_  
 (Date)