

## Financial Policy

*Our mission is to provide the highest quality and most comprehensive dental care. We strive to make optimal care accessible by offering multiple payment options to ease financial concerns.*

### **Payment Options:**

You may choose from the following:  
Cash, Check, Credit Card, Debit Card  
No-Interest Payment Plans via our lending partners: Care Credit, Alphaeon, Lending Club, & Cherry Payment Plans

- Pay overtime with no interest
- Convenient low monthly payments
- No annual fees or pre-payment penalties

### **Payment Policy:**

Payment is required prior to completion of treatment.

If treatment is discontinued, a refund will be issued minus the cost of care received.

Hygiene copayments are due at the time of service.

### **Insurance Information:**

We assist in maximizing insurance benefits and directly bill insurance for reimbursement.

However;

Patients are responsible for understanding their coverage and benefits.

All insurance-related questions must be directed to your insurance provider.

For orthodontic patients using insurance, please notify us immediately of any coverage changes during treatment. Failure to do so may result in

financial adjustments based on your original agreement. We strive to provide accurate insurance estimates based on your plan's information.

If you have questions, please contact our insurance coordinator or your insurance provider directly.

### **Additional Fees & Policies:**

Returned Checks: Subject to a \$40.00 fee.

Unpaid Balances: Payment is expected within 90 days of service, regardless of insurance status.

Delinquent accounts may be subject to collection proceedings, including financial and billing charges.

### **Appointment Policy:**

Reserved time with our providers requires a minimum 24-hour notice for cancellations/reschedules.

Cancellations or rescheduled appointments without notice may incur a \$100.00 fee (exceptions considered case-by-case).

We are here to assist and ensure you have a seamless and outstanding experience. Please reach out with any concerns.

### **Acknowledgment & Agreement:**

I acknowledge that I am responsible for full payment of all treatments performed at David Bradley DDS PC. I understand that dental insurance may cover some services, but I am financially responsible for any unpaid balances.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

