

FINANCIAL POLICY/RELEASE FOR THE DENTAL OFFICE OF DAVID P. YOUNG, DMD, FICOI

The primary goal of our dental practice is to provide the highest quality oral health care in the most gentle, efficient and enthusiastic manner. Since our practice is also a business with obligations that must be met, we ask that all patients pay for their treatment in full on the day of each visit to our office, unless prior arrangements have been made. We would be happy to discuss a third party payment arrangement made thru care credit, which allows you the option of paying over time with zero interest. We are happy to assist you thru this process and figure an option that fits within your budget. We will do our best to give you a rough estimate of your investment in your dental health for each upcoming visit, based on your individual treatment plan. You will be given a very close estimate of your next visits total bill. Please bring cash, check, or credit card at the time of treatment. With a proper diagnosis and a timely treatment plan, most estimates we provide are accurate. Outstanding balances on your account are discouraged, and must be cleared before the next appointment for any account member, or within 30 days of treatment, whichever comes first. Appointments for non-emergency treatment may need to be postponed pending payment of outstanding balances. Amount due and not paid in full within 30 days will be charged interest at a rate of 1.5% per month, in addition to a \$5.00 monthly billing fee per statement. Delinquent balances over 90 days old will be referred to Collection agency. All referred accounts are marked "Inactive". In order to have your account "Reactivated", and continue to receive dental treatment in our office, the delinquent balance must be paid in full. A returned check fee of \$40.00 (subject to change as bank fees increase) will be added to your account for any returned check. Before we accept another payment by check, the \$40.00 fee plus full payment for the check that did not clear, must be paid in cash, or by Visa, MasterCard, or Discover. We realize your time is valuable and do our very best to respect that. Your dental appointments are scheduled carefully. Time, trained personnel and dental equipment are reserved for each procedure. Missed appointments add to the cost of dental care when reserved facilities are left waiting empty. We request 24 hours advance notice for rescheduling your appointment. Your account will be charged a broken appointment fee of \$55.00 for repeatedly missed appointments without proper notification. We are always here to answer any of your financial questions, and work with you in any way we can; please don't hesitate to ask any of our qualified team members!

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorized release of any information concerning myself or my child's healthcare, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning myself or my child's health care, advise and treatment to another dentist.

I am responsible for all costs of dental treatment.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

Patient's or Guardian's Signature _____ Date _____