Sawnee
FAMILY DENTISTRY

FINANCIAL POLICY

At our practice, we wish to provide the highest quality dental care in a compassionate, courteous, and professional manner. Our goal is to educate, motivate, and promote good health. We have a sincere commitment to each other and to our family of patients.

Financial Agreement:

Payment for services rendered are due at the time of service which includes and are not limited to co-pays and deductibles for our patients with insurance. Payments may be made using cash, check, all major credit cards and FSA. We also offer third party financing through Care Credit.

Optional payment terms:

1. **50/50 plan:** Patients can pay 50% of services/copay at the start of treatment and the remaining 50% when services are completed. This will only apply if more than one appointment is needed for treatment.
2. **Term Loan:** We can offer 12 months interest free financing through Care Credit upon approval. There is no down payment required, no annual fee, and no prepayment penalty.
3. **Cash Discount:** 5% accounting courtesy will apply for all services over $500 that is paid in full by cash/check prior to commencement of treatment.

Treatment plans are subject to change with additional charges based on new findings.

Appointments:

In an effort to keep our costs down, we try to maintain an effective appointment system. With that in mind, we require at least 24 hour notice for any cancellation. A $50 fee will be charged after 2 broken appointments without the proper notification.

Insurance Information:

It is our pleasure to assist with claim submissions and to answer any questions you may have concerning your dental benefits. Insurance is designed to help with the cost of care but it is not designed to determine treatment. Dr. Lee will diagnose treatment based on what is best for your dental health, not your insurance coverage. We will help maximize your allowable benefits, however, any balance that remains after insurance has paid or denied a claim is the responsibility of the patient.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy shall also cover your dependent children if applicable.

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Patient's Name (please print)

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Patient's Signature **Date**

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Sawnee Family Dentistry Representative **Date**