Carolina Dental Care

Appointment & Financial Policy / Agreement: Thank you for choosing our office to provide your dental care. We consider it a great honor to have been chosen to do so. We are committed to providing our patients with the best possible care. Our philosophy is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This financial agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask.

Dental insurance: We are not a participating provider with any insurance plans. As a courtesy, we will gladly submit your dental claims for our services, provided that we have complete and current insurance information. However, in all cases, the patient remains responsible for the account. Your insurance is a contract between you, your employer and the insurance company. We are not a third party to that contract. Our relationship is with you and not your insurance company. By providing insurance information to our office you agree that we have your permission to process insurance claims. All charges that are not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all insurance companies will send the insurance payment to our office; they send it to the subscriber. If this is the case with your insurance, payment is due at the times services are rendered. Not all the services we provide are covered benefits. Benefits differ from one company to another. If your insurance pays directly to you, we will require payment for services up front on the day they are provided. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment. If you have dental insurance it is your responsibility to tell us before treatment is rendered. Although we may estimate your insurance benefits, please keep in mind, these are only estimates. Knowledge of benefits, as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our insurance estimate. Patients without dental insurance coverage: Payment is expected at each visit for services rendered unless prior written arrangements have been made with our office.

Minor patients: The parent/guardian scheduling the appointment accepts financial responsibility for the appointment and it is expected that the payment/co-payment will be paid at the time of service, by the parent/guardian accompanying the child, without any exception. The Parents/Guardians need to discuss (between themselves) financial arrangements prior to the minor's appointment. We ask that you do not put our office in the middle. Payment is expected at each visit for services rendered unless prior written arrangements have been made with our office.

Payment Policy: We accept cash, personal checks, debit cards, Care Credit, Health Flex Savings cards, Visa, MasterCard and Discover. Returned checks: A $35.00 returned check charge applies when a check is returned by the bank for insufficient funds. Finance charges and collection fees: All balances are due upon receipt. Finance charges will be applied to all balances not paid within 30 days of the monthly billing date. A late charge of 1.5% on the balance then unpaid and owed will be assessed each month until paid. It is your responsibility to ensure your insurance company pays promptly so you can avoid finance charges. We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account. Overdue balance: An account with an unpaid balance past 90 days will be sent to our collection agency. At that

time, you will be responsible and agree to pay for any and all costs incurred in the collection of your debt: interest on the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.

Confirming Appointment: Do you have a preference on how would you like to confirm your appointment email, phone call or text?

- ☐ **Email:**
- ☐ **Phone:**
- ☐ **Text:**

By signing this document, I agree to receive marketing text messages from Carolina Dental Care at the phone number provided. I understand these messages may be sent using an automatic telephone dialing system and that consent is not a condition of purchase. Reply STOP to unsubscribe, or HELP for help. Msg & data rates may apply.

Broken or missed appointment: Appointments not kept or changed with less than 24 hours notice are considered broken. Broken appointments prevent others from receiving the dental care they deserve. Please be considerate and inform us in advance if you need to change your appointment. Fee for missed appointment if 24-hour notice is not given: To reschedule or cancel an appointment, you must notify us at least twenty- four (24) hours in advance to avoid a missed appointment fee of up to $25. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

Appointment Policy: Once an appointment has been made, please remember this time has been reserved exclusively for you. A room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you. Appointments cancelled or failed without two business days' notice are subject to charge. Repeated cancellations or missed appointments will result in loss of future appointment privileges. Consent & Authorization: By scheduling appointments at Carolina Dental Care , I authorize dental treatment for myself and/or minor child(ren), and agree to pay all related professional fees. I have read and understand this document in its entirety, outlining office policies and financial policies of Carolina Dental Care. Without any reservations, I agree to abide by the policies outlined herein. By signing below I certify that I understand and agree to the above statement.

Form completed by: Name (Print) _____

Signature_____

Relationship to patient _____

Date _____

Reviewed by staff member _____

Date _____

Please list minor patients that are on your account