Financial Policy

We are happy that you chose us for your dental care. Please carefully read, initial, and sign this agreement. Let our finance team know if you have any questions:

Initial: _____ 1) You will need to pay your portion of the charges as you go. This includes annual deductibles, co-payments, and charges your dental benefit plan refuses to pay. **Any balance on your account remaining after we have received payment from your dental benefit plan is expected to be paid within 30 days**.

Initial: _____ 2) Patients are responsible for knowing their dental benefit plan. This includes, but is not limited to: eligibility, maximums, deductibles, co-payments, frequency limitations, and waiting periods. As a courtesy, we can help you verify dental benefit information. However, it is ultimately **your** responsibility to know what is covered under your dental benefit plan.

Initial: _____ 3) We are happy to prepare the necessary forms to help obtain payment from your dental benefit plan, providing you give us all the information required to process your claims.

Initial: _____ 4) When a dental benefit plan reimburses patients directly, payment is due in full at the time of service.

Initial: _____ 5) In order to file your dental claims, the SSN of the patient and/or subscriber must be provided. **Otherwise, the patient will be responsible for paying in full at the time of service and submitting their own dental claims for reimbursement.**

Initial: _____ 6) Patients without a dental benefit plan will be expected to pay for treatment on the date that services are rendered – **no exceptions**. Ask us about our in-house savings plan, Scola Wellness Club. We also have financing options available through Compassionate Finance and Care Credit. Please ask a team member for more information if you are interested.

Initial: _____ 7) Account balances **60 days** or older will be subject to a finance charge of 2% per month. Account balances over **90 days** old will be referred to our collection agency unless prior arrangements have been made. All collection expenses are the account holder's responsibility.

Initial: _____ 8) If you must change your appointment, **we require at least 24 hours notice to avoid a $50.00 cancellation fee.** Any appointment changes **MUST** be done during our normal business hours. We hope you understand that broken appointments delay treatment. It is our goal to help you achieve optimum dental health. We can do that best when you are here spending that quality time with us.

Initial: _____ 9) If you suspend or terminate your care against the advice of your doctor, all outstanding charges that have not been paid by your dental benefit plan will become immediately due and payable by you personally before you leave.

By signing below, you acknowledge that you have read this policy and agree with the terms. Your signature below also assigns dental benefit plan payments directly to the dentist.

_____ _____

Patient Name (please print) Date

_____ _____

Signature (Parent/Guardian if patient is a minor) Relationship to patient