



FINANCIAL POLICY

All of us at Pearlfection Dentistry are happy to have you as a patient. We are committed to providing you with the highest quality dental care using only the best technology and materials available in the market today. Dental treatment is an excellent investment in an individual’s medical care and emotional well-being. It is our goal to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile. Let us take a moment to review the financial policy of our practice.

Payment Options: We accept cash, checks, all major credit cards (Discover, Visa, MasterCard, American Express) and Care Credit as options to meet your portion of the fee. Many emergency visits and cosmetic procedures require full payment at the time of service. In addition, other financial options are available for our patients. These arrangements must be made with a financial coordinator prior to scheduling your treatment.

PearlFection Dentistry requires payment at the beginning of your treatment. A financial deposit of the lesser of 50% or \$200 is required to reserve your treatment appointment and a deposit of \$300 if required for any treatment involving sedation.

A fee of \$50 is charged for patients who miss or cancel any appointment with a hygienist or general doctor without 48-hour notice and the entire deposit is forfeited for missed or cancelled appointments with a specialist, without 48-hour notice

PearlFection charges \$35 for returned checks and \$25 for any accounts sent to an outside collections service.

A credit card is required to be kept on file. By signing below, you authorize PearlFection to charge that card, without further notification, any balance less than or equal to \$50. Patients will be notified of balances larger than \$50 via invoice.

As a courtesy to you, we can accept assignment of benefit payments from many insurance companies. This step will reduce your immediate, out-of-pocket expenditures. The outlined estimate we provide is based on limited information obtained from your insurance company. **We expect you to pay your estimated share of the total fee at your visit.** You can always request a predetermination of benefits be submitted prior to any work being done. Predeterminations do not guarantee benefits will be paid but do help get a more accurate estimate. **We do our best to estimate what your insurance will pay, but regardless if your insurance pays some, all, or none of the costs of your work, you are 100% responsible for the full cost.**

You must provide us with the necessary names, addresses, and identification numbers along with proof of insurance eligibility if you would like for us to bill your insurance company for you. If your insurance company does not remit payment within **60 days**, the unpaid balance will be due from you. We may add a billing fee to all accounts 60 days past due.

PAST DUE BALANCE – INTEREST RATE We reserve the right to charge 8% interest on past due balances beginning 30 days past the due date. We will charge \$10 per statement sent out after the first statement has been sent out.

AUTHORIZATION AND RELEASE I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Pearlfection Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Patient/Guardian Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____