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FINANCIAL POLICY

WE MAKE EVERY EFFORT TO KEEP THE COST OF OUR FEES REASONABLE. WE REQUIRE PAYMENT AT THE TIME OF SERVICE AND ACCEPT CASH, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER AND ALSO OFFER TIME PAYMENT PLANS. IF YOU HAVE DENTAL INSURANCE, WE WILL BE GLAD TO FILL OUT THE PROPER FORMS. BUT THE INSURANCE INFORMATION WE HAVE ON FILL MUST BE COMPLETE. YOU SHOULD ALSO UNDERSTAND:

1.) YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT. OUR RELATIONSHIP IS WITH YOU, NOT WITH YOUR INSURANCE COMPANY. ALSO CHARGES ARE <u>YOUR</u> RESPONSIBILITY, WHETHER YOUR INSURANCE COMPANY PAYS OR NOT. NOT <u>ALL</u> SERVICES ARE A COVERED BENEFIT.

2.) IF THE INSURANCE COMPANY DOES NOT PAY IN FULL IN 45 DAYS, WE MAY REQUIRE YOU TO PAY THE BALANCE VIA CASH, CHECK OR CREDIT CARD.

3.) IN CASES OF DIVORCED PATIENTS, THE PARENT THAT BRINGS THE CHILD WILL BE DEEMED RESPONSIBLE FOR PAYMENT.

4.) ANY CHECK RETURNED TO US BY THE BANK DUE TO INSUFFICIENT FUNDS, ETC.. WILL RESULT IN A $25.00 SSERVICE CHARGE TO YOUR ACCOUNT.

5.) BILLS ARE SENT FROM THIS OFFICE ON A MONTHLY BASIS WITH A STATEMENT MAILED TO YOUR BILLING ADDRESS IN THE FIRST WEEK OF EACH MONTH. PAYMENT IS EXPECTED WITHIN 30 DAYS.

6.) IF YOUR POLICY REQUIRES A REFERRAL AND YOU RECEIVE SERVICES WITHOUT SUCH, YOU ASSUME FINANCIAL RESPONSIBILITY.

7.) <u>DEFAULT</u> WILL BE DEFINED AS NONPAYMENT RECEIVED WITHIN A <u>60</u> DAY PRERIOD OR TWO MONTHLY BILLING CYCLES.

INTEREST FREE TIME PAYMENT SCHEDULE

ACCOUNTS WILL REMAIN INTEREST FREE IF BALANCE IS PAID WITHIN TIME FRAME LISTED BELOW WITH REGULAR MONTHLY PAYMENTS.

UNPAID BALANCE: OVER $300.00 IF PAID IN 6 MONTHS OR LESS
UNDER $300.00 IF PAID IN 3 MONTHS OR LESS

NOTE: WE UNDERSTAND THAT TEMPORARY FINANCIAL PROBLEMS MAY EFFECT TIMELY PAYMENTS OF YOUR BALANCE. BUT IT IS YOUR RESPONSIBILITY TO COMMUNICATE ANY SUCH PROBLEM TO US IN WRITING OR VIA TELEPHONE SO WE CAN ASSIST YOU IN THE MANAGEMENT OF YOUR ACCOUNT. IF YOU ARE UNABLE TO FULLFILL YOU FINANCIAL OBLIGATIONS IN ACCORDANCE WITH THE ABOVE PAYMENT SCHEDULE, YOUR ACCOUNT CAN BE CONVERTED TO AN INTEREST BEARING TIME PAYMENT SCHEDULE. HOWEVER, IF A PAYMENT IS NOT RECEIVED WITHIN A <u>60</u> DAY PERIOD AND YOU HAVE NOT CONTACTED THIS OFFICE TO MAKE FINANCIAL ARRANGEMENTS, THE ACCOUNT WILL BE DETERMINED TO BE IN DEFAULT. AT THAT TIME THE BALANCE WILL AUTOMATICALLY BEGIN TO REQUIRE INTEREST CHARGES AT THE RATE OF 1 1/2% PER MONTH (18% PER ANNUM.). IF THE ACCOUNT REMAINS IN DEFAULT FOR AN ADDITIONAL 30 DAYS, TOTALLING 90 DAYS WITHOUT PAYMENT, THE ACCOUNT WILL BE REFERRED FOR COLLECTION WITH THE RESPONSIBLE PARTY AGREEING TO PAY RESPONSIBLE COLLECTION COSTS AND FEES. INCLUDING ATTORNEY FEES AND COSTS AND ALSO REPORTED TO NATIONAL CREDIT BUREAU ORGANIZATIONS, SIGNIFICANTLY AND ADVERSELY AFFECTING YOUR CREDIT HISTORY.

INTEREST BEARING TIME PAYMENT SCHEDULE

INTEREST BEARING ACCOUNTS ARE FOR ALL ACCOUNTS THAT WISH A PAYMENT SCHEDULE FOR 6 MONTHS OR LONGER. BUT NOT TO EXCEED 12 MONTHS OR ONE CALENDAR YEAR FROM PROCEDURE COMPLETION DATE. INTEREST FOR THIS ACCOUNT WILL BE CHARGED AT A RATE OF 1 ½% PER MONTH (18% PER ANNUM.) WITH MONTHLY PAYMENTS TO BE DIVIDED EQUALLY. PATIENTS OPTING FOR THIS PLAN WILL BE REQUIRED TO SIGN A PROMISSORY NOTE THAT WILL LIST TERMS AND AMOUNT OF THE MONTHLY PAYMENTS.

NOTE: TERMS OF THIS PLAN ARE AS FOLLOWS: PAYMENTS ARE TO BE MADE MONTHLY IN ACCORDANCE WITH THE PROMISSORY NOTE. THERE IS NO PENALTY FOR PRE-PAYMENT. IF A PAYMENT IS NOT RECEIVED WITHIN A **60** DAY PERIOD, THE ACCOUNT WILL BE CONSIDERED TO BE IN DEFAULT. THE TOTAL REMAININF BALANCE WILL IMMEDIATELY BECOME DUE, AND A STATEMENT WILL BE SENT TO YOUR BILLING ADDRESS INFORMING YOU OF YOUR DELIQUENCY STATUS. IF THE ACCOUNT IS NOT PAID IN FULL WITH AN ADDITIONAL 30 DAYS FOR A TOTAL OF **90** DAYS WITHOUT PAYMENT, THE ACCOUNT WILL BE REFERRED FOR COLLECTION, WITH THE RESPONSIBLE PARTY AGREEING TO PAY RESPONSIBLE COLLECTION COSTS AND FEES. INCLUDING ATTORNEYS FEES AND COURT COSTS. YOUR DEFAULT WILL ALSO BE REPORTED TO NATIONAL CREDIT BUREAU ORGANIZATIONS AND WILL SIGNIFICANTLY AND ADVERSELY AFFECT YOUR CREDIT HISTORY.

CREDIT CARD TIME PAYMENT SCHEDULE

PATIENTS CAN OPT TO PAY THE BALANCE ON THEIR ACCOUNTS UTILIZING THEIR CREDIT CARD. THIS IS ESPECIALLY HELPFUL FOR PATIENTS WHO WISH TO SPREAD THEIR PAYMENTS, WITHOUT MAXING OUT THEIR AVAILABLE LINE OF CREDIT ON ONE PURCHASE OR WHO PREFER PAYING A SMALLER MONTHLY (MINIMUM DUE) AMOUNT, OR WHO WOULD LIKE LONGER THAN 12 MONTHS BY WHICH TO PAY OFF THEIR BALANCE TO THE CREDIT CARD COMPANY. BY SIGNING A PRE-AUTHORIZATION FORM, AN AGREED TO AMOUNT CAN BE BILLED TO YOUR CREDIT CARD MONTHLY UNTIL THE BALANCE WITH THIS OFFICE HAS BEEN PAID IN FULL.

PATIENTS WITH INSURANCE COVERAGE

FOR ALL PROCEDURES EXCEEDING $200.00 / MULTI VISIT TREATMENT
50% OF THE PATIENTS BALANCE OR CO-PAY IS DUE AT THE START OF THE PROCEDURE, WITH THE REMAINING 50% DUE AT COMPLETION OF THE PROCEDURE. THIS NORMALLY APPLIES TO ALL PROCEDURES THAT REQUIRE A PRE-TREATMENT ESTIMATE FROM YOUR INSURANCE. ANY OF THE TIME PAYMENT ARRANGEMENTS CAN BE MADE PRIOR TO THE START OF THE PROCEDURE CONCERNING THE 50% DUE AT COMPLETION, HOWEVER THE INITIAL 50% MUST BE PAID AT THE START OF THE PROCEDURE.

NOTE: PRE-TREATMENT ESTIMATES FROM YOUR INSURANCE COMPANY ARE CALCULATED BASED ON CURRENT AVAILABLE BENEFITS AND PATIENTS ELIGABLITY. ESTIMATES ARE SUBJECT TO MODIFICATION BASED UPON REMANING BENEFITS AVAILABLE.

PATIENTS WITH NO INSURANCE COVERAGE

FOR ALL PROCEDURES EXCEEDING $200.00 / MULTI-VISIT TREATMENT
50% OF THE COST OF THE PROCEDURE **MUST** BE PAID AT THE START OF THE PROCEDURE. THE REMAINING 50% IS DUE AT THE COMPLETION OF THE PROCEDURE, UNLESS TIME PAYMENT ARRANGEMENTS ARE MADE PRIOR TO THE START OF THE PROCEDURE.

THIS PRESENTATION OF OUR FINANCIAL POLICY IS PRESENTED TO YOU TO DEMONSTRATE ALL THE POSSIBLE PAYMENT OPTIONS AVAILABLE TO YOU AT OUR OFFICE, AND TO MAKE YOU AWARE OF YOUR FINANCIAL OBLIGATIONS AS WELL AS ASSISTING YOU IN MAKING YOUR TREATMENT LESS OF A FINANCIAL BURDEN, ENABLING YOU TO AFFORD TREATMENT YOU OTHERWISE THOUGHT YOU COULDN'T.

X

DATE

SIGNATURE

I UNDERSTAND AND AGREE TO THE FINANCIAL POLICY AS STATED ABOVE. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT.