

OUR OFFICE AND FINANCIAL POLICIES  
Smart Smiles Dental, LLC

Thank you for choosing SMART SMILES DENTAL, LLC for all your dental needs. We are committed to providing you with excellent care and convenient financial arrangements in order to insure the best possible experience.

**PAYMENT**

Payment in full for services planned for that treatment day is expected at the time of service unless prior arrangements have been made with our financial coordinator. Please ask about our several payment options. We accept Visa, MasterCard, Discover and American Express.

*\*WE DO NOT ACCEPT PERSONAL CHECKS\**

**INSURANCE**

Our office is committed to helping our patients maximize their insurance benefits. As you may be aware, dental insurance is extremely complex. We are always available to answer your questions; however, **your insurance policy is an agreement between you and your employer/insurance carrier and as the dentist, we are not party to that agreement. Your patient portion must be paid before or at the time of service .We ask our patient to provide us with their complete dental insurance information. If the information provided is incorrect; you will be responsible for payment in full immediately and submission of claims for any treatment rendered.** As a service to our patient, we will process all primary insurance claims for services and allow them 30 days to render payment in full. After 45 days, the patient is responsible for the entire balance and it will be due in full. The qualities of insurance policies vary greatly; therefore we can estimate your coverage in good faith, but cannot guarantee coverage due to complexities of insurance contracts.

**MINORS**

Payments for services for the treatment of minors is the responsibility of the adult accompanying that minor.

**MISSED APPOINTMENTS**

Once an appointment has been made, please remember that this time has been specifically reserved for you. We will make every effort to remind you of your appointment but, ultimately, your appointments are your responsibility. We reserve the right to charge a \$75.00/hour fee for any appointment missed or cancelled within a 48-hour period of the appointment.

**SERVICE CHARGES**

We will charge a 1.5% monthly (18% annual percentage rate) or billing charge which will be applied to all accounts over 60 days past due. For all Ach Debits that are made over the phone and rejected we will charge a \$25.00 service fee. Any fees incurred to collect payments from a professional agency will be billed to and payable by the patient or the patient's responsible party.

**FINANCIAL CONSENT**

The patient or responsible party agrees to be fully responsible for the total treatment performed in this office.

I understand and agree to this Office and Financial Policy

\_\_\_\_\_  
*Signature of Patient/Responsible Party*

\_\_\_\_\_  
*Date*