lechtenberg & young DENTAL

FINANCIAL POLICY

All services rendered are due and payable at the time of treatment. A service charge of 1.5% per month will be added to all accounts outstanding greater than 30 days. An estimate of fees for your treatment plan recommended by the doctor and/or hygienist will be discussed with you during your financial consultation. We offer a 10% discount to patients who pay at the time of their treatment, with cash or check for treatment plans of $800 or more. We also accept Care Credit, a third party payment option, Master Card, Visa and Discover.

We will be glad to submit any claims to your insurance, but please provide a copy of your insurance card(s). **Upon your request**, the estimate will be sent to your insurance company for verification of benefits prior to treatment. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance company.**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependent and also responsible for paying any co-payment and deductibles that my insurance does not cover. In the event that my account is outstanding greater than 90 days, I agree to pay all costs of collections, including, but not limited to, reasonable attorney's fees.

_____ _____

Patient Name Date

_____

Patient Signature (Parent or Guardian signature if a minor)

CANCELLATION POLICY

Your appointment time has been reserved especially for you. In the event that you must reschedule or cancel, please provide at least a 48 hour Courtesy Notice so that we may accommodate others who need care. Exceptions will be made for emergencies or illness. For appointments cancelled or rescheduled for the 2nd time without providing a Courtesy Notice, there will be a $40.00 dollar cancellation fee.

THANK YOU FOR YOUR CONSIDERATION!

_____ _____

Patient Signature (Parent or Guardian signature if a minor) Date